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14. ABSTRACT

This study to enhance the ability of base, major command (MAJCOM) and Air Staff IDS to reduce death, injury, and degraded force readiness through (a) dissemination of base, MAJCOM, and AF prevalences of secretive problems; (b) provision of base-level information to identify and prioritize risk and protective factors, (c) assistance in bases' selecting and implementing empirically supported interventions, and (d) evaluation of whether prevalences were lowered.

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INTRODUCTION:

One-quarter of airmen with serious levels of family maltreatment, suicidality, and problematic alcohol/drug use (i.e., at a level that, incontrovertibly, the AF would intervene therapeutically, administratively, or legally) degrades the AF's ability to fly, fight, and win our nation's wars. However, only 1 out of 6 reaches out to anyone in uniform (friend, first sergeant, commander, service agency). Thus, a prevention approach that decreases secretive problems by improving non-sensitive community health factors (i.e., targeted risk and protective factors) would be both a viable and valuable military readiness effort. This study aims to enhance the ability of base, major command (MAJCOM), and Air Staff IDSs to reduce death, injury, and degraded force readiness through (a) dissemination of base, MAJCOM, and AF prevalences of secretive problems; (b) provision of base-level information to identify and prioritize risk and protective factors, (c) assistance in bases' selecting and implementing empirically supported interventions, and (d) evaluation of whether prevalences were lowered. We will conduct **a** randomized, controlled prevention trial to test the effectiveness of the prevention science-guided NORTH STAR framework in reducing targeted risk factors; increasing targeted protective factors; and reducing base prevalences of family maltreatment, suicidality, and problematic alcohol and drug use. Twelve matched pairs of bases will volunteer and be randomly assigned to either (a) the NORTH STAR implementation condition or (b) the control condition (which will receive comparable prevalence and risk/protective factor information from the 2006 AF Community Assessment (CA+) but not receive any NORTH STAR training, support, or consultation). At the 12 test and 12 control bases we expect average participation (i.e., 912 AD members and 349 spouses per base) in the CA+, providing us with excellent statistical power.

BODY:

Year 1

✓Complete *Task 1: Stony Brook will revise orientation and training materials, guides to prevention interventions.*

All materials were revised and updated. Materials began being distributed to bases in November, 2006.

✓Complete *Task 2: Work with AFMOA/SG3OO and CA contractor to prepare for AF-wide administration of CA and supplement (CA+).*

Task 3: Consult with AFMOA/SG3OO and CA contractor on AF-wide CA and supplement survey administration.

We helped the AFMOA/SG3OO and CA contractor successfully launch the administration of the CA and the CA+. We worked with their teams to finalize questionnaire items and beta-test the web survey.

✓Complete *Task 4: Base leadership pre-assessment at 24 sites: IDS, CAIB, command members' perceptions of community readiness and efficacy.*

Pre-assessment questionnaires were distributed to all 24 bases in September, 2006 and were returned by early December, 2006.

✓Complete *Task 5: Analyze CA and supplement data (CA+) for all sites (AF-wide)*

In Progress *Task 6 Provide results of CA+ on secretive problems and risk/protective factors, to intervention sites; work with IDSs to identify other base-level data sources on relevant risk and protective factors*

AF-level results were briefed to Air Staff in October, 2006. Prior to the in-person training of any base within a Major Command, each Major Command received an in-person brief detailing results for all bases within the Major Command. These briefings began in October, 2006 and were completed in January, 2007. Feedback reports and briefing slides detailing base-level results have been completed for the 24 sites (NORTH STAR bases and control bases). These materials were distributed to all control bases in December, 2006. To date, nine of NORTH STAR have received their results (at their in-person training). The other three bases will be trained by mid-April, 2007. All delays in training have been due to scheduling challenges with individual bases and leadership.

√Complete *Task 7 Provide results of CA+ to all non-intervention sites AF-wide (parallel analyses and format as for intervention bases).*
These results were provided to all non-intervention sites in December, 2006.

In Progress *Task 8 Meet semi-annually with military advisory board (November and May)*
NORTH STAR progress was briefed at the meeting in December, 2006, and is on the agenda for the June, 2007 meeting.

In Progress *Task 9 (Begin at end of year 1, continue into beginning of year 2) Leadership orientation to framework and plan at intervention sites.*
These briefings occur at the in-person trainings, which have been conducted at 9 of the 12 intervention sites, with the final 3 scheduled to occur by mid-April, 2007.

In Progress *Task 10: (Begin at end of year 1, continue into beginning of year 2) On-site visits at 12 test bases:*

- *In-brief with base leadership on CA+ results and purpose of visit*
- *Team training for IDS (half day)*
- *Intensive training for appointed members and the development of an initial action plan (additional two days). Training will comprehensively review the project, research plan, and all phases of the community intervention model. This training will also include an introduction to project communication and support structure (see task 11).*
- *Out-brief to CAIB to present initial action plan*

These briefings occur at the in-person trainings, which have been conducted at 9 of the 12 intervention sites, with the final 3 scheduled to occur by mid-April, 2007.

KEY RESEARCH ACCOMPLISHMENTS: Bulleted list of key research accomplishments emanating from this research.

- Successfully conducted anonymous survey of family maltreatment, alcohol and drug problems, and suicidality.
- Revised and produced all NORTH STAR materials to implement evidence-based community prevention approach at test bases.
- Completed all initial data analyses
    - Successfully completed training at nine bases.

REPORTABLE OUTCOMES: Provide a list of reportable outcomes that have resulted from this research to include:

Presentations of survey results have been limited to Air Force research meetings. The Guidebook and Training Manual have been included, and the website has been established.

CONCLUSION: The purpose of this project is to test the effectiveness of the NORTH STAR approach to community prevention. To prepare for this test, training materials had to be revised, an AF survey had to be conducted, bases' readiness for empirically guided prevention had to be assessed, the results of the AF survey had to be analyzed and briefed, and each of the bases in the test condition had to be trained. All of these tasks were accomplished, putting our controlled, randomized, prevention trial on track for completion

REFERENCES: List all references pertinent to the report using a standard journal format (i.e. format used in *Science*, *Military Medicine*, etc.).

Not applicable.

APPENDICES:

Guidebook

Training Manual

SUPPORTING DATA: N/A

Enhancing IDS: A Guidebook to Activities That Work

Third Edition

Part of the NORTH STAR Evaluation

From the Family Translational Research Group at the
State University of New York at Stony Brook

STONY BROOK
STATE UNIVERSITY OF NEW YORK

Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work

Development Information

Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work was developed by the Family Translational Research Group at the State University of New York at Stony Brook, with support from the US Department of Defense DAMD170310166. This guidebook is created as an integral part of the NORTH STAR evaluation.

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Restricted Usage

Because NORTH STAR is being tested, this guidebook may only be used at US Air Force Academy, Aviano AB, Bolling AFB, Buckley AFB, Eielson AFB, Grand Forks AFB, Holloman AFB, Lackland AFB, Luke AFB, Minot AFB, Osan AB, Patrick AFB, and Kadena AB. It may not be shared outside those bases without the explicit approval of the AFMOA/SGZF Research Director (comm: (703) 681-6305) and the Stony Brook research team.

Citation for entire guidebook:

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Snarr, J. D. (2005). Introduction enhancing the Integrated Delivery System (IDS): A guidebook to activities that work. In A. M. S. Slep & R. E. Heyman (Eds.), *Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work, Second Edition* (pp. 7-11). State University of New York at Stony Brook.

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Snarr, J. D. & Gaudino-Goering, E. A., E (2005). Anger. In A. M. S. Slep & R. E. Heyman (Eds.), *Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work* (pp. 103-108). State University of New York at Stony Brook.

Snarr, J. D. (2005). Depressive symptoms. In A. M. S. Slep & R. E. Heyman (Eds.), *Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work, Second Edition* (pp. 109-116). State University of New York at Stony Brook.

Snarr, J. D. (2005). Thoughts and beliefs about alcohol and drugs. In A. M. S. Slep & R. E. Heyman (Eds.), *Enhancing the Integrated Delivery System (IDS): A Guidebook to Activities That Work, Second Edition* (pp. 117-120). State University of New York at Stony Brook.

Introduction to Enhancing IDS: A Guidebook to Activities That Work

Enhancing IDS: A Guidebook to Activities That Work is designed to help USAF IDSs (Integrated Delivery Services Teams) select effective activities and interventions to be included in their action plans as part of the NORTH STAR Initiative. The NORTH STAR system allows each IDS to choose which targets and interventions to focus on, based on data from the most recent CA and as the resources that are available to the IDS. Such flexibility, pioneered by Hawkins, Catalano and colleagues in their "Communities That Care" program for youth problems, has resulted in excellent community acceptability and promising prevention outcomes.

What are "Activities that Work?"

The guidebook presents interventions and activities that have been shown to reduce known risk factors and increase protective factors for the "secretive problems" of family maltreatment, substance abuse, and/or suicidality. The activities included here represent only a small fraction of those that have been developed for these purposes. Strict criteria were used to select interventions for inclusion. All of the activities presented in the guidebook:

- Target research-based *risk* and/or *protective* factors for the above-mentioned secretive problems. Interventions that directly target family maltreatment, substance abuse, or suicidality are not included.

- Are available for implementation. That is, all information and/or materials necessary to carry them out can be obtained from the intervention developer, an independent distributor, a website, and/or other sources.

- Can be practically and feasibly implemented on a community scale. For example, interventions involving individual psychotherapy are not included in the guidebook. Although psychotherapy has been shown to have many potentially beneficial effects, it is time- and resource-intensive. On the other hand, group workshops are much more cost-effective than individual therapy and are included if they meet the other criteria.

- Are empirically supported. That is, they have produced significant positive effects on the relevant risk and protective factors in community trials and/or controlled studies.

The criterion of empirical support is especially important. Many available interventions have never been evaluated. Most of these interventions "make sense," and quite a few are being widely implemented. The people and organizations that are engaging in such activities often believe that the interventions are effective, but there is no evidence that they work. In contrast, every intervention included in this guidebook has been tested and proven to work.

Of course, the fact that a particular intervention has empirical support does *not* mean that it is perfect. No activity has ever been shown to work for all people, families, organizations, or communities under all circumstances. For example, most of the activities presented here have been validated only with civilians. It may be that AF communities, AD members, or AF families differ from their civilian counterparts in ways that make an activity less effective or even prevent it from having any beneficial effects at all. On the other hand, it may also be that factors within a

military population are likely to *increase* the effectiveness of a given intervention. In any case, even within the same population (e.g., on a given AF base), not everyone will benefit to the same degree—or at all—from any given activity. The activities in this guidebook may not be perfect, but they have been evaluated and have evidence that they can be effective.

Indeed, we have attempted to include the *best available* interventions and activities for each target. Wherever well-validated interventions are available, we have not included other activities that may target the same risk or protective factors, for which the evidence is not as strong. There are also many activities and interventions that may well be effective, but have not yet been evaluated; these are also not presented here—at least, not yet. This guidebook is intended to be a living document. As new interventions and activities are developed and validated, and as new evidence becomes available for existing interventions, the online version of the guidebook will be updated. All members of the NORTH STAR listserv will be notified whenever these online guidebook updates are posted. Be sure to check the website often for the latest empirically-supported innovations!

How is the guidebook organized?

The effective activities have been grouped according to the level at which intervention takes place. These levels of intervention are presented in order of increasing specificity: 1) Community, 2) Organization, 3) Family, and 4) Individual. Each level is further subdivided according to the relevant risk and protective factors. For example, if you turn to page 31, you will see that the potential target of "Marital/Romantic Relationships" is listed under the Family level of intervention. Within each target, the guidebook is structured as follows:

Introduction

The introduction to a potential target contains a brief discussion of what makes this target an important risk/protective factor.

Items in 2003 AF Community Assessment	Item #s
1. Items in the CA that assess this target are listed here. 2. Chapters on targets that are not assessed by the current CA do not contain this section.	For example: L1, N9, N10, L2

Activities/Interventions

This is simply a list of the interventions and activities that are known to affect the target. It should be noted that many activities are known to influence more than one target. Interventions are listed under each target that they affect; however, a full description of the activity is given only in the chapter on the primary target.

Descriptions of these interventions then follow. For example, if you turn to page 36, you will see the listing for *Couples Coping Enhancement Training (CCET)*, an intervention primarily targeting Marital/Romantic Relationships. The listing for each activity is structured as follows:

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL

A given intervention may have many different effects. This section lists all of the NORTH STAR targets that the intervention is known to influence. The primary target is listed first, and it is in the chapter for this primary target that the full intervention description can be found.

DESCRIPTION

This section contains a brief summary of the intervention. Here we discuss what activities are involved and what the intervention was designed to accomplish.

MINIMAL IMPLEMENTATION

This section details who should do what, how often, for how long, if the intervention is to be counted as part of the NORTH STAR Initiative. It may be that a less intense version of a given activity could be effective; however, each intervention has only been validated under conditions of at least the intensity and duration described here.

DOCUMENTED RESULTS (Empirical Evidence: **Rating**)

This section briefly describes the empirical evidence for the effectiveness of the intervention. Specific studies and results are discussed. In addition, we have given each intervention a global Empirical Evidence rating (i.e., **Good**, **Better**, or **Best**). These ratings are our interpretation of the overall quality of the evidence showing that each intervention works, and may help you to decide which activities to implement. The criteria used for these ratings are as follows:

Best

These interventions have been very well validated. Most have existed for many years and have been tested in multiple studies with large sample sizes and control groups. Usually, their effects are known to last for an extended period of time. If an intervention is new, it can receive a rating of **Best** if it (a) is particularly innovative, (b) has been evaluated in at least one well-designed study, and (c) has produced especially impressive results (e.g., *Family Thriving Program*, page 47). These interventions truly are the "cream of the crop."

Better

These interventions have fairly strong evidence for their effectiveness, but have not been as well validated as the **Best** activities. Often, these interventions are relatively new and thus have not been evaluated in as many studies. The research may have involved a large sample size but no control group, or a control group but a small sample size. Also, long-term follow-up data may not yet be available.

Good

These interventions are promising, and there is at least some evidence that they work. Studies of the effectiveness of these interventions may have involved a small sample size and no control group. If long-term follow-up data is available, it shows that the effects of these activities may not last as long as those labeled **Better** or **Best**. An intervention will also receive a rating of **Good** if only some of the studies evaluating it have found that it works, or if it only works with certain people or under particular circumstances.

RESOURCES REQUIRED

This section indicates the physical, financial, and human resources that would be necessary in order to implement the intervention as described. Specific cost information is included whenever such is available.

WHERE TO FIND MORE INFORMATION

This section provides contact information for the intervention developers, distributors, and/or sources of necessary materials. Other sources of helpful, relevant information may also be provided.

References

This section contains citations for the books and articles that have been cited in the chapter introduction and intervention descriptions. These are provided so that anyone interested in additional information (e.g., on the actual validation studies) can refer to the original source.

Charts

Starting on page 104, you will find two charts that may be useful when navigating the guidebook. Chart 1 lists all of the activities described in the guidebook, organized according to the quality of the empirical evidence that supports each intervention (**Best**, **Better**, or **Good**). Chart 2 indicates which targets are affected by each activity, and which interventions can be implemented to influence a given risk or protective factor.

Bibliography

The bibliography is an alphabetical list of all references cited in the guidebook.

Community

Introduction

Communities are defined by more than geographical boundaries. More importantly, they are identified by the interactions among their inhabitants and the connections among people formed through common goals or beliefs. When someone refers to a "good community," they most likely mean a place whose residents feel safe from crime and violence; trust, respect, and support one another; and share responsibility for the quality of the community. Such community bonds have many benefits — both for communities themselves and for the individuals and families who live there (for reviews, see Chavis & Newbrough, 1986; Putnam, 2000). Strong communities are able to solve problems more quickly and more easily and tend to have less crime. Children who live in tight-knit communities are healthier, watch less TV, and do better in school. People in close communities tend to be more successful occupationally, have better physical health, and report being generally happier than in communities marked by social distance and mistrust.

It would seem, then, that strong communities should be an important ingredient in the recipe for us and our society to become "healthy, wealthy, and wise." Unfortunately, as Harvard political scientist Dr. Robert Putnam (2000) has documented, the last four decades have brought what Putnam calls "the collapse of American community." Americans today are less politically active than we have ever been in the past — fewer of us vote than in almost any other Western democracy. Membership and participation growth in many civic groups, religious institutions, professional organizations, and leisure-time associations (such as bowling leagues) has stalled or, in many cases, drastically declined. We are giving less money to charity and volunteering less time for good causes. We spend less time with friends and are increasingly unlikely to know our neighbors. Not surprisingly, Americans today tend to believe that their neighbors are less honest and trustworthy than their parents or grandparents did. Connecting with the community, particularly the off-base community, may be especially challenging for highly mobile AF families, as one of the strongest predictors of a psychological sense of community is the number of years that one expects to live in the community (Glynn, 1986).

In sum, the benefits of belonging to a strong, tight-knit community can be tremendous, but Americans' sense of community is weakening. In response to this decline, hundreds of interventions have been developed to bolster American communities; unfortunately, very few have ever been empirically evaluated. The interventions presented in this section are exceptions to the rule — their ability to effectively accomplish their stated goal(s) has been scientifically tested and validated.

Items in 2003 AF Community Assessment	Item #s
1. Safety from crime and violence	L1, N9, N10, L2
2. Community unity/sense of shared responsibility for quality of community	C10, E1, Q1, Q2, Q3
3. Satisfaction with community	E2, K1, K3
4. Neighbors are friendly and supportive	S1, S2, S3, S4

Activities/Interventions
Community Gardens
Neighborhood Watch/Working it Out
Improved Street Lighting

Community Gardens

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Unity ★ Support from Neighbors			★ Healthy Diet ★ Personal Coping

DESCRIPTION

A community garden is nothing more than a plot of land where members of a community raise plants — primarily vegetables — in individual or communal plots. Community gardens are becoming more and more widespread; in 1991, it was estimated that one million U.S. households were annually involved in community gardening (Blair, Giesecke, & Sherman, 1991).

MINIMAL IMPLEMENTATION

At a minimum, it is necessary to provide land, prepare the soil, and invite/encourage members and their families to plant gardens on it. An organization to manage the garden (e.g., decides who gets to plant where, etc.) should also be set up for effective implementation.

Due to relatively frequent PCSing inherent to military life, it may be beneficial to provide tools and a tool storage facility rather than asking gardeners to provide their own. Gardening information, advice, classes, and/or workshops might also be provided. It is recommended that bases wishing to start community gardens use and teach a gardening system like "Square Foot Gardening" (see Where to Find More Information below), which provides maximum harvest and enjoyment but requires minimal space, tools, and work.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Researchers have found that community gardening can provide many benefits. For example, since 1977, the Penn State Urban Gardening Program has provided the technical assistance and educational support necessary to help turn over 500 vacant lots in Philadelphia into community gardens. A study (Blair, Giesecke, & Sherman, 1991) compared 144 gardeners from garden sites around the city with 67 controls who lived near the sites but did not garden. Compared to the non-gardeners, gardeners:

- Expressed significantly higher life satisfaction.
- Were more likely to participate in food distribution projects, neighborhood cleanups or beautification projects, and neighborhood barbecues and social events.
- Were more likely to view their neighbors as friendly.
- Consumed 6 out of 14 vegetable categories significantly *more* frequently, while consuming milk products, citrus fruits and juices, sweet foods (i.e., desserts and sweet snacks), and sweet drinks (e.g., soda) *less* frequently.

RESOURCES REQUIRED

The most important necessary resource is plot of land that receives as much daylight as possible during the local growing season. Also, one or more responsible individuals must be able and willing to organize and oversee this relatively long-term activity. Seeds for community garden projects are available free of charge from the America the Beautiful Fund (see below). Tools and storage facilities (e.g., sheds) range in price.

It may also be beneficial to form alliances with local "Master Gardeners" — people who have agreed to volunteer their time teaching others how to garden. They are almost always more than happy to provide advice, information, classes, and/or workshops free of charge. To find Master Gardeners in your vicinity, contact your state Cooperative Extension Office.

WHERE TO FIND MORE INFORMATION

Information on how to create a successful community garden:

American Community Garden Association
1916 Sussex Road
Blacksburg, VA 24060
Tel: (540) 552-5550
Fax: (540) 961-1463
Email: jthies@managementconsultantscorp.com?subject=ACGA
URL: www.communitygarden.org

Free seed information:

America the Beautiful Fund
1730 K St., NW, Suite 1002
Washington, DC 20006
URL: www.america-the-beautiful.org

Information on Square Foot Gardening:

The Square Foot Gardening Foundation
P.O. Box 10
Eden, UT 84310
TOLL-FREE: (877) 828-1188
Email: info@squarefootgardening.com
URL: www.squarefootgardening.com

Neighborhood Watch/ Working it Out

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Safety ★ Community Unity ★ Community Satisfaction			

DESCRIPTION

It goes by various names — Neighborhood Watch, Block Watch, Crime Watch, Window Watch, Town Watch — but whatever it is called, this type of community-based social initiative is becoming increasingly popular. The objectives: reduce crime, fight social isolation, and promote a sense of joint responsibility for the community. The National Crime Prevention Council (NCPC; 2002) states that a Neighborhood Watch is "one of the most effective and least costly ways to prevent crime and reduce fear" (p. 1).

A typical Watch group organizes neighbors to look out for each others' families and property, report any suspicious activities or crimes in progress, and work together to make their community a better place to live (NCPC, n.d.). "Working it Out" takes the Neighborhood Watch a step further; in this intervention, neighbors sign up in groups of 4 or 5 to walk the streets of their neighborhood during peak crime hours. As in all Watch activities, members are not to confront people engaged in suspicious or criminal activity, rather merely to observe and report.

MINIMAL IMPLEMENTATION

Members and their families should be encouraged to sponsor Watch groups or join pre-existing groups in their neighborhoods. For example, a base representative may be assigned to provide newly-arrived member families with information on existing groups in their communities. In addition, good relationships should be fostered between Watch groups and security forces or municipal law enforcement officials.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The Neighborhood Watch concept is highly respected and widely implemented, and police departments around the country subjectively report significant reductions in crime and fear as a result of Watch interventions (NCPC, n.d.). Unfortunately, however, empirical evidence of their effectiveness is limited. In one study of the "Working it Out" version of Neighborhood Watch (Levine, 1986), two communities in Cambridge Massachusetts began Watch interventions — complete with "walking patrols" — after their areas experienced a sudden crime wave. The following findings were reported:

- The crime wave was halted within a year. The average number of housebreaks per month was reduced by almost 75% (from 54/month to 15/month) and remained at or below the reduced level over four years of follow-up.

- The police department consistently attributed a major portion of the reduction in crime to the Watch program.
- "Walking crime watchers" reported feeling substantially more secure in their homes and in the community.
- Participants also reported an enhanced sense of community, as well as higher satisfaction with and confidence in the future of the community.

These results must be viewed with some caution, as no comparisons were made to other communities or individuals who did not implement or participate in the intervention.

RESOURCES REQUIRED

Information and suggestions regarding how to set up initiate new Watch groups are available from the groups listed below. Information on already-existing groups will of course have to be collected locally. Other than information and the means of distributing it, no other resources are necessary.

WHERE TO FIND MORE INFORMATION

National Crime Prevention Council
1000 Connecticut Avenue, NW
13th Floor
Washington, DC 20036
Tel: (202) 466-6272
Fax: (202) 296-1356
URL: www.ncpc.org

National Association of Town Watch
P.O. Box 303
Wynnewood, PA 19096
TOLL-FREE: (800) NITE-OUT
Email: info@natw.org
URL: www.nationaltownwatch.org

Improved Street Lighting

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Safety			

DESCRIPTION

In addition to social initiatives like the Neighborhood Watch program, modifications in the physical environment can affect perceived and/or actual safety (see Casteel & Peek-Asa, 2000). The goals of an Improved Street Lighting program, for example, are twofold: to reduce crime itself, and to reduce the fear of crime and the avoidance behaviors (e.g., staying indoors at night) associated with such fears (Herbert & Davidson, 1994). Although it is not yet clear whether brighter streets actually reduce crime, people do seem to *feel* safer if their street is brightly lit (see below).

MINIMAL IMPLEMENTATION

In some areas, implementation may involve something as simple as using brighter bulbs, while in others, it may require wholesale replacement of current lighting fixtures. In any case, lighting along residential streets and sidewalks should be improved so that (a) the light is well-distributed (i.e., minimal "dark pockets"), and (b) a minimum illuminance level of between 1 and 2.5 lux is achieved, as measured by a photometer. (One lux is the brightness of a lit candle one meter away in a dark room, or the light of a full moon; 2.5 lux is brighter than the interior of many fashionable bars and restaurants; Kripke, n.d.).

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

In one study conducted in England (Herbert & Davidson, 1994), people who lived on 5 streets in each of two cities were surveyed both shortly before and within a few months after the lighting on their streets was improved as described above. The results of the post-improvement survey generally showed reductions in participants' (a) fears of falling victim to a crime and (b) perceptions that many kinds of crime (e.g., robbery, vandalism) were big problems in their areas. People — especially women and the elderly — reported being much less afraid to go out after dark, and sharp increases in the numbers of women and older adults on the streets after 9:00 p.m. were observed. Interestingly, men's perceptions of the risks faced by women were decreased even more than the perceptions of the women themselves.

Unfortunately, the time spanned by the study was too short to tell whether improving the residential street lighting had any impact on actual crime in the area. It should also be noted that brighter streets appeared to lead to *increased* perceptions of certain problems, including dog noises and mess, broken paving, and drunken behavior. The authors of the study attributed this to "a combination of visibility and exposure. More residents [were] on the streets at night and the better street lighting [made] them more aware of the problem[s]" (p. 345).

RESOURCES REQUIRED

Specific resources will depend entirely on the size of the area(s) to be improved and the current state of lighting on the streets. It may be necessary to form partnerships with and/or secure grants or donations from local/state governments, businesses, and/or nonprofit organizations.

WHERE TO FIND MORE INFORMATION

National Crime Prevention Council
1000 Connecticut Avenue, NW
13th Floor
Washington, DC 20036
Tel: (202) 466-6272
Fax: (202) 296-1356
URL: www.ncpc.org

Community References

Introduction

Chavis, D. M., & Newbrough, J. R. (1986). The meaning of "community" in community psychology. *Journal of Community Psychology, 14,* 335-340.

Glynn, T. J. (1986). Neighborhood and sense of community. *Journal of Community Psychology, 14,* 341-352.

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community.* New York: Simon and Schuster.

Community Gardens

Blair, D., Giesecke, C. C., & Sherman, S. (1991). A dietary, social and economic evaluation of the Philadelphia Urban Gardening Project. *Journal of Nutrition Education, 23,* 161-167.

Neighborhood Watch/ Working It Out

Levine, M. D. (1986). Working it out: A community re-creation approach to crime prevention. *Journal of Community Psychology, 14,* 378-390.

National Crime Prevention Council. (n.d.). *Neighborhood watch organizer's guide.* Retrieved September 15, 2003, from http://www.ncpc.org/cms/cms-upload/ncpc/files/orgz.pdf

National Crime Prevention Council. (2002). *Joining a Neighborhood Watch.* Retrieved September 15, 2003, from http://www.ncpc.org/cms/cms-upload/ncpc/files/nwjoin.pdf

Improved Street Lighting

Casteel, C., & Peek-Asa, C. (2000). Effectiveness of crime prevention through environmental design (CPTED) in reducing robberies. *American Journal of Preventive Medicine, 18,* 99-115.

Herbert, D., & Davidson, N. (1994). Modifying the built environment: The impact of improved street lighting. *Geoforum. 25,* 339-350.

Kripke, D. M. (n.d.). *Brighten your life.* Retrieved September 13, 2003, from http://www.brightenyourlife.info/

Organizational Factors

Introduction

In recent years, researchers and human resource professionals have increasingly begun turning their attentions to the problem of work-related stress. What they have found is striking. In a summary of the civilian job stress research literature, Sauter et al. (1999, pp. 4-5) cited the following findings:

- Between 25% and 40% of workers report high levels of work-related stress.
- One-fourth of employees view their jobs as the number one stressor in their lives.
- Three-fourths of employees believe the worker has more on-the-job stress than a generation ago.
- Problems at work are more strongly associated with health complaints than are any other life stressor — more so than even financial problems or family problems.

Indeed, work-related stress has been linked to a wide variety of indicators of ill health and decreased well-being, including headache, sleep disturbances, difficulty concentrating, short temper, disturbed relationships with family and friends, upset stomach, cardiovascular disease, back and upper-extremity musculoskeletal disorders, and various mental health problems, such as depression (European Commission, 1997; Sauter, Murphy, & Hurrell, 1990; Sauter et al., 1999). Job performance can also be affected, as elevated levels of stress may impair an employee's ability to attend to finite details (Fujigaki, 1993) and/or to make creative decisions based on all the necessary and relevant information (Isen, Daubman, & Nowicki, 1987). Stress in the workplace can affect not only the well-being of employees, but that of the organization itself, due to increased rates of absenteeism, decreased efficiency, and increased costs (Murphy, 1996; Sauter, Murphy, et al 1999). For example, health care expenditures are almost 50% higher for workers who report high levels of stress (Goetzel et al., 1998).

Reductions in work-related stress can be achieved in several ways. The proven approaches described below range from simple and specific (i.e., *Personal Stereo Use*) to broad and complex (i.e., *Stress. . .at Work*).

Items in 2003 AF Community Assessment	Item #s
1. Exposure to stressful work schedule/conditions	D1, D2, D3
2. Ability to manage work demands	H1e, M4b-c

Activities/Interventions
Personal Stereo Use
Stress. . .at Work
Coping with Work and Family Stress™

Personal Stereo Use

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress ★ Satisfaction With Air Force		

DESCRIPTION

It has long been documented that listening to music while working can potentially have positive effects on employees' mood states and performance (e.g., Wyatt & Langdon, 1937). However, the results are mixed — that is, not everyone works better to music. The development of personal-stereo headsets (e.g., Sony's Walkman) made it possible to enhance the work environment of those employees who prefer working to music without annoying or distracting those who do not. The design of this activity is simple: Allow personal stereos to be used in the workplace.

MINIMAL IMPLEMENTATION

The intervention works by allowing employees to listen to music if they wish, for as long as they wish, and to whatever style of music they wish. This can be accomplished by permitting or encouraging employees to bring in their own personal stereos and music, or by setting up a music library and providing both headsets and cassette tapes or CDs. Employees should of course be encouraged to exercise discretion in listening (e.g., they should not listen when doing so might be dangerous or make it impossible to do their jobs properly).

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

In 1995, Oldham and colleagues conducted a study of personal stereo use in the business office of a large retail organization. Half of those employees who indicated that, if permitted, they would use a personal stereo at work were allowed to do so for four weeks; the rest were not. Compared to (a) the employees who did not want to listen to music while working, (b) those who wanted to do so but were not permitted, and (c) themselves before and after the four-week allowed listening period, on-the-job personal-stereo listeners demonstrated the following results:

- More relaxed;
- Less nervous;
- More enthusiastic;
- Less fatigued;
- Less distracted by their work environments;
- Better able to concentrate on their jobs;
- More satisfied with the employing organization;
- Less intention to leave their current job in the near future;
- Higher supervisor-rated job performance.

Oldham et al. (1995) found further that the best explanation for the increases in job-performance and organizational satisfaction was the improved ability of personal-stereo

users to relax while working. The effects were greatest for employees in relatively simple jobs; in fact, listening was more hindrance than help for employees with extremely complex jobs.

RESOURCES REQUIRED

Other than employee participation, practically no resources are needed for this intervention to be successful.

WHERE TO FIND MORE INFORMATION

N/A

Stress. . .at Work

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress		

DESCRIPTION

The National Institute for Occupational Safety and Health (NIOSH) is the federal agency responsible for conducting research and making recommendations for the prevention of civilian work-related illness and injury, including work-related stress. NIOSH has recently published a booklet, entitled *Stress. . .at Work* (Sauter et al., 1999), which contains not an intervention per se but rather a set of empirically-guided recommendations for designing and implementing a job-stress-reducing intervention tailored to the needs of a given organization. Of course, these recommendations may or may not be applicable within a military context or to certain occupations.

There is evidence that the effects of workplace stress management interventions — which typically educate employees about stress without considering the environment within which they work — often decreases stress only for the short term. Thus, NIOSH recommends that organizations work not only to enable individual employees to cope better with work-related stress, but also — and perhaps more importantly — to make fundamental stress-reducing and/or -preventing changes in work conditions, policies, and procedures. For example, possible ways to change the organization to prevent job stress include:

- Ensuring that the workload is matched to employees' capabilities and resources
- Clearly defining employees' roles and responsibilities
- Improving communications — reducing uncertainty about career development and future employment prospects
- Providing opportunities for social interaction among employees
- Establishing reasonable work schedules that are compatible with outside demands and responsibilities (e.g., family)

MINIMAL IMPLEMENTATION

While the NIOSH authors (Sauter et al., 1999) make no specific, universal prescriptions for job stress prevention, the process for any organization will include identifying potential problems, designing and implementing an intervention, and evaluating the intervention's success. In order for this process to succeed, preparations must include:

- Making employees and the organization more aware of the nature of stress and its risk factors and consequences
- Committing top organizational authorities to support the intervention
- Incorporating employee feedback and involvement in all phases of the process (i.e., problem identification, intervention design, implementation, and evaluation)
- Establishing the technical capacity to conduct the intervention (e.g., specialized training for base staff or use of job stress consultants)
-

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The NIOSH recommendations for decreasing job stress are based on the accumulated results of a wide array of research studies. Unfortunately, there is as yet no direct evidence that following their guidelines specifically alleviates stress for the individual within the workplace. However, there is some very good indirect evidence for the effectiveness of this type of intervention. For example, the St. Paul Fire and Marine Insurance Company conducted multiple studies of stress prevention activities in hospital settings (Jones et al., 1988). Intervention elements included (a) employee and management education regarding job stress, (b) changes in hospital policies and procedures to reduce organizational sources of stress, and (c) the establishment of employee assistance programs. In one study, after stress prevention activities were implemented in a 700-bed hospital, the frequency of medication errors declined by 50%. In a second study, malpractice claims were reduced by 70% in 22 hospitals that implemented stress prevention activities, while no reduction in malpractice claims was found in a matched group of 22 hospitals where stress prevention activities were not instigated.

RESOURCES REQUIRED

NIOSH will work directly with any organization to gather the necessary tools to create change within a given organization. NIOSH will provide information and technical assistance, as well as videotapes and other training materials, all free of charge. Successful implementation of this kind of strategy will require a specialized technical support team, plus the cooperation of personnel at all levels of the base organization. In addition, it may be necessary or beneficial to hire one or more psychologists as consultants to assist with preliminary assessment, intervention design, and/or effectiveness evaluation. Fees will vary depending on the nature and amount of consultant involvement.

WHERE TO FIND MORE INFORMATION

National Institute for Occupational Safety and Health
Hubert H. Humphrey Bldg.
200 Independence Ave., SW
Room 715H
Washington, DC 20201
TOLL-FREE: (800) 356-4674; from outside the U.S.: (513) 533-8328
Fax: (513) 533-8573
Email: eidtechinfo@cdc.gov
URL: www.cdc.gov/niosh/topics/stress/

State psychological associations maintain a listing of licensed psychologists who may be able to help with stress-related issues. Contact the American Psychological Association

(APA; see below) or your State psychological association for more information, or refer to the APA internet site with this information (http://apa.org/).

American Psychological Association (APA)
750 First St., N.E.
Washington, DC 20002-4242
TOLL-FREE: (800) 374-2721
Tel: (202) 336-5500

COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress		★ Personal Coping ★ Depressive Symptoms ★ Anxiety ★ Alcohol Expectancies

DESCRIPTION

Coping with Work and Family Stress™ is a workplace-based coping skills intervention designed to help employees learn and apply effective strategies for coping with stressors at work and at home. Participants learn how to deal with problems by addressing the problem, rethinking the problem, and/or managing the stress.

During the course of the intervention, group facilitators lead participants in discussions and practice exercises comprising three broad skill areas: (a) How to directly eliminate or modify sources of stress (e.g., problem-solving skills), (b) How to modify the meaning of a stressful situation or experience (e.g., cognitive-restructuring techniques), and (c) How to reduce the impact of stress (e.g., relaxation strategies, promoting healthy lifestyles).

MINIMAL IMPLEMENTATION

During the efficacy trials, groups of 12-18 employees met with an intervention facilitator for 16 weekly, 1.5-hour sessions. However, it should be noted that the developer of the program has assured NORTH STAR staff that the curriculum could be adapted for use with larger groups (even up to 100 participants), as long as multiple facilitators are present for each session.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Two large efficacy studies have been conducted on Coping with Work and Family Stress™ (Kline & Snow, 1994; Snow & Kline, 1991; Snow & Kline, 1995; Snow, Swan, Raghavan, Connell, & Klein, 2003; Snow, Swan, & Wilton, 2002). Male and female workforce members were randomly assigned to either intervention participation or a control group. Results of these studies suggest that participation led to (a) reductions in work and/or family stressors, (b) improvements in perceived social support at work, (c) increased use of effective coping strategies, (d) lessened use of avoidant coping strategies, and (e) decreases in alcohol consumption, use of alcohol as a means of reducing tension, and psychological symptoms. Some positive effects of the intervention were observed immediately following the intervention, with additional effects emerging at six-month follow-up.

RESOURCES REQUIRED

Two- or 3-day intensive training for facilitators and all necessary materials are available from The Consultation Center at Yale University. (See their fee schedule for costs.) The 3-day training is particularly recommended if the program is to be adapted for use with large audiences. Facilitators need not be mental health professionals. Once training is complete, no additional consumable materials need be purchased. Ongoing direct costs

for implementing the program include facilitator time, copying of materials for participants, and (possibly) ongoing technical support.

WHERE TO FIND MORE INFORMATION

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The Consultation Center and Division of Prevention and Community Research
Department of Psychiatry, Yale University School of Medicine
389 Whitney Avenue
New Haven, CT 06511
Tel: 203-789-7645
Fax: 203-562-6355
Email: david.snow@yale.edu

For training, technical assistance, and materials, contact:
Susan O. Zimmerman, LCSW
The Consultation Center and Division of Prevention and Community Research
Department of Psychiatry, Yale University School of Medicine
Tel: 203-789-7645
Fax: 203-562-6355
Email: susan.zimmerman@yale.edu
URL: http://www.theconsultationcenter.org/WFS.htm

Organizational Factors References

Introduction

European Commission. (1997). *Report on work-related stress.* Brussels: Author.

Fujigaki, Y. (1993). Stress analysis: A new perspective on peopleware. *American Programmer, 6,* 33-38.

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Isen, A. M., Daubman, K. A., & Nowicki, G. P. (1987). Positive affect facilitates creative problem solving. *Journal of Personality and Social Psychology, 52,* 1122-1131.

Murphy, L. R. (1996). Stress management in the work settings: A critical review of health effects. *American Journal of Health Promotion, 10,* 112-135.

Sauter, S. L., Murphy, L., Colligan, M., Swanson, N., Hurrel, J., Jr., Scharf, F., Jr., et al. (1999). *Stress . . . at work* (DHHS Publication No. 99-101).Cincinnati, OH: National Institute for Occupational Safety and Health.

Sauter, S. L., Murphy, L. R., & Hurrell, J. J. (1990). Prevention of work-related psychological disorders: A national strategy proposed by the National Institutes for Occupational Safety and Health (NIOSH). *American Psychologist, 45,* 1146-1158.

Personal Stereo Use

Oldham, G. R., Cummings, A., Mischel, L. J., Schmidtke, J. M., & Zhou, J. (1995) Listen while you work? Quasi-experimental relations between personal-stereo headset use and employee work responses. *Journal of Applied Psychology, 80,* 547-564.

Wyatt, S., & Langdon, J. N. (1937). Fatigue and boredom in repetitive work. *Industrial Health Research Board Report No. 77.* London: Her Majesty's Stationery Office.

Stress…At Work

Sauter, S. L., Murphy, L., Colligan, M., Swanson, N., Hurrel, J., Jr., Scharf, F., Jr., et al. (1999). *Stress . . . at work* (DHHS Publication No. 99-101).Cincinnati, OH: National Institute for Occupational Safety and Health.

Coping with Work and Family Stress™

Kline, M. L., & Snow, D. L. (1994). Effects of a worksite coping skills intervention on the stress, social support, and health outcomes of working mothers. *The Journal of Primary Prevention, 15,* 105-121.

Snow, D. L., & Kline, M. L. (1991). A worksite coping skills intervention: Effects on women's psychological symptomatology and substance use. *The Community Psychologist, 24,* 14-17.

Snow, D. L., & Kline, M. L. (1995). Preventive interventions in the workplace to reduce negative psychiatric consequences of work and family stress. In C. M. Mazure (Ed.), *Does stress cause psychiatric illness?* (pp. 221-270). Washington, DC: American Psychiatric Press.

Snow, D. L., Swan, S. C., Raghavan, C., Connell, C. M., & Klein, I. (2003). The relationship of work stressors, coping and social support to psychological symptoms among female secretarial employees. *Work & Stress, 17,* 241-263.

Snow, D. L., Swan, S. C., & Wilton, L. (2002). A workplace coping skills intervention to prevent alcohol abuse. In J. Bennett & W. E. K. Lehman (Eds.), *Preventing workplace substance abuse: Beyond drug testing to wellness* (pp. 57-96). Washington, DC: American Psychological Association.

Work Group Cohesion/Preparedness

Introduction

"Work group cohesiveness" refers to the ability of a work group to trust and communicate with one another, to work together as a team. It can be a tremendous challenge to take a diverse group of employees and turn them into a cohesive unit that integrates well with the entire organization. The fact that people differ means that conflict will almost inevitably arise (Rayeski & Bryant, 1994, p. 217). Conflicts can occur among individual members or between the team and the rest of the organization (Capozzoli, 1995; Amason, 1996; Kezsbom, 1992).

In spite of the potential obstacles, however, there are tremendous potential benefits to building cohesive work groups. Employees in such groups are less likely to report individual job stress, problem drinking, and climates that support drinking (Bennett & Lehman, 1998; Delaney & Ames, 1995). In theory, this is at least partly because a work group that is unified is more aware of its membership. If one member of a cohesive team is faltering — be it in the form of personal stress, substance use, or inability to meet the demands of the job — the other members are likely to lend support and take the necessary steps to assist the member in need (Bennett, Lehman, & Reynolds, 2000). There are benefits for the organization as well. For example, teams that work well together are able to execute and make necessary adjustments to assigned tasks more efficiently than a team that is not cohesive (Mohrman, Cohen, & Mohrman, 1995). Thus, promoting cohesive units can also improve and/or protect organizational efficiency and productivity (see Capozzoli, 1995).

The intervention listed below (*Team Awareness*) has been shown to significantly improve work group cohesiveness, particularly in areas relevant to drug and alcohol use and abuse.

Items in 2003 AF Community Assessment	Item #s
1. Good relationships with coworkers, supervisor, and supervisees	F1
2. Members of squadron are cohesive	G1a
3. Members of squadron work together as a team	G1b
4. Trust that squadron members, officers, and NCOs will perform well in a deployment or crisis situation	G1d-f

Activities/Interventions
Team Awareness

Team Awareness

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Knowledge of Drug and Alcohol Policy ★ Trust in EAP ★ Work Group Cohesion/Preparedness		

DESCRIPTION

Team Awareness is a workplace-based training strategy that was designed to address behavioral and organizational risks for substance abuse among employees and their coworkers (Bennett, Lehman, & Reynolds, 2000). The intervention increases employees' motivation to seek help for their own problems and enhances team awareness of peers who may be in need of assistance. The intervention helps both individuals and the team to meet desired outcomes by promoting group cohesiveness, improving communications among team members and between team members and management, and strengthening awareness of potential risk factors for the employee and the organization.

During Team Awareness training, the facilitator uses a combination of lecture, group discussion, small group exercises, and innovative games to accomplish the following goals:

- Increase employees' awareness of the importance of their role in substance abuse prevention in their worksite.
- Create positive attitudes toward company policies as tools for risk prevention.
- Reduce risky levels of supervisor and coworker tolerance of substance abuse.
- Increase awareness of the nature of stress and its risk factors and consequences, including the role of substance use. Promote healthy alternatives for dealing with stress.
- Improve workplace communication skills by reviewing listening skills and identifying work communication norms.
- Develop peer referral skills and employee alliance with Employee Assistance Programs (EAPs).

MINIMAL IMPLEMENTATION

The intervention developer and/or on-site facilitator first conduct preliminary focus groups and hold preparatory meetings in order to collect information regarding organizational policy and to tailor the intervention to fit the needs and resources of the specific organization. The actual team-oriented awareness training is an 8-hour activity administered across two 4-hour group sessions, held two weeks apart. Each group is composed of 10 to 25 employees — most often people who work closely with one another.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Team Awareness is the first workplace-based training recognized as a Model Program by the Substance Abuse and Mental Health Services Administration. It has been shown to

enhance trust within work groups, improve communications, and strengthen employees' knowledge of and trust in EAPs and organizational policies (Bennett & Lehman, 2001; Lehman, Reynolds, & Bennett, 2003). At six-month follow-up, compared to others within their organizations, employees who participated in Team Awareness were also:

- Twice as likely to decrease problem drinking behaviors
- Less likely to arrive at work under the influence of drugs or alcohol
- Less likely to work with or miss work due to a hangover
- More likely to work in a group that encourages coworkers to stop a drinking or drug habit
- More likely to contact their EAP for help

RESOURCES REQUIRED

Once at least one base representative has been trained as an on-site intervention facilitator, it may only be necessary to consult the intervention developers when technical assistance is required. Training costs approximately $3000 per facilitator; however, group discounts are available. Manuals and other materials are available free of charge and can be downloaded at www.organizationalwellness.com.

WHERE TO FIND MORE INFORMATION

Joel B. Bennett, Ph.D.
Organizational Wellness & Learning Systems
4413 Overton Terrace
Fort Worth, TX 76109
Tel: (817) 921-4260
Email: owls@charter.net
URL: www.organizationalwellness.com

Work Group Cohesiveness References

Introduction

Amason, A. C. (1996). Distinguishing the effects of functional and dysfunctional conflict on strategic decision making: Resolving a paradox for top management teams. *Academy of Management Journal, 39,* 123-148.

Bennett, J. B., & Lehman, W. E. K. (1998). Workplace drinking climate, stress, and problem indicators: Assessing the influence of teamwork (group cohesion). *Journal of Studies on Alcohol, 59,* 608-618.

Bennett, J. B., Lehman, W. E. K., & Reynolds, S. (2000). Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program. *Prevention Science, 1,* 157-172.

Capozzoli, T. K. (1995). Conflict resolution: A key ingredient in successful teams. *Supervision, 56,* 3-5.

Delaney, W. P., & Ames, G. (1995). Work team attitudes, drinking norms, and workplace drinking. *Journal of Drug Issues, 25,* 275-290.

Kezsbom, D. S. (1992). Bringing order to chaos: Pinpointing sources of conflict in the nineties. *Cost Engineering, 34,* 9-16.

Mohrman, S. A., Cohen, S. G., & Mohrman, Jr., A. M. (1995). *Designing team-based organizations: New forms for knowledge work.* San Francisco, CA: Jossey-Bass.

Rayeski, E., & Bryant, J. D. (1994). Team resolution process: A guideline for teams to manage conflict, performance, and discipline. In M. Beyerlein & M. Bullock (Eds.), *The International Conference on Work Teams Proceedings: Anniversary Collection. The Best of 1990 - 1994* (pp. 215-221). Denton, TX: University of North Texas, Center for the Study of Work Teams.

Varney, G. H. (1989). *Building productive teams: An action guide and resource book.* San Francisco, CA: Jossey-Bass, Inc.

Team Awareness

Bennett, J. B., & Lehman, W. E. K. (2001). Workplace substance abuse prevention and help seeking: Comparing team-oriented and informational training. *Journal of Occupational Health Psychology, 6,* 243-254.

Bennett, J. B., Lehman, W. E. K., & Reynolds, S. (2000). Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program.

Lehman, W. E. K., Reynolds, G. S., & Bennett, J. B. (2003). Team and informational trainings for workplace substance abuse prevention. In J. B. Bennett & W. E. K. Lehman, (Eds.), *Preventing workplace substance abuse: Beyond drug testing to wellness* (pp. 165-201) Washington, DC: American Psychological Association.

Relationship Satisfaction

Introduction

Successful, satisfying couple relationships promote physical, mental, and interpersonal health, whereas unsuccessful, conflicted relationships negatively affect many aspects of well-being and create financial and social burdens for communities (see Waite & Gallagher, 2000, for a review). Unfortunately, at present, marriages in America are more likely to be unsuccessful than not. Between 40% and 50% of U.S. couples currently marrying for the first time will eventually divorce (Kreider & Fields, 2002). Of course, not all distressed relationships are reflected in divorce rates — many couples never divorce, remaining in distressed relationships (Notarius & Markman, 1993). Indeed, one in five married couples reports significant marital dissatisfaction at any given time (Beach & O'Leary, 1986). Furthermore, most distressed relationships have at least one incident of physical aggression per year (Heyman & Slep, 2003).

Many distressed couples seek professional help for their problems and there is good evidence that some forms of couples' therapy are better than no help at all — at least for a time (e.g., Hahlweg & Markman, 1988). However, it has been argued that rather than merely trying to fix relationships that are already "broken," it may be more effective to provide relatively satisfied couples with information and skills that can help prevent marital problems from developing (Behrens & Sanders, 1992; Carroll & Doherty, 2003; Sayers, Kohn, & Heavey, 1998).

The interventions listed in this section have been shown to significantly reduce and/or prevent marital conflict and distress. One (PREP) has been designed for and primarily evaluated with premarital couples and newlyweds, while the others are known to be effective with longer-married couples.

Items in 2003 AF Community Assessment	Item #s
1. Perception of good relationship	M6a
2. Stability	M6b
3. Equal partnership	M6c
4. Commitment	M6d
5. Happiness	M7

Activities/Interventions
Prevention and Relationship Enhancement Program (PREP)
Relationship Enhancement (RE)
Couples Coping Enhancement Training (CCET)
Triple P (Levels 4 & 5 only)

Prevention and Relationship Enhancement Program (PREP)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction	

DESCRIPTION

Negative patterns of communication (e.g., hostility, withdrawal, domineering) are strongly associated with couple distress, violence, and breakup (Holtzworth-Munroe, et al., 1995; Markman, Floyd, Stanley, & Storaasli, 1988; Gottman & Krokoff, 1989). The Prevention and Relationship Enhancement Program (PREP) is primarily designed to help couples communicate — without fighting — about sensitive issues and areas of conflict, and to enhance commitment, sensuality, friendship, and fun.

PREP participants hear lectures and view videotapes on communication skills, identify issues relevant to their relationships, and are assigned to practice important skills at home. In some versions of PREP, trained consultants coach couples through in-session practices. Readings are often assigned from the book *Fighting for Your Marriage* (Markman, Stanley, & Blumberg, 2001).

MINIMAL IMPLEMENTATION

In the most intense version of PREP, participants attend six 2-hour weekly sessions in groups of four to eight couples. However, more typical formats consist of either (a) 4-8 couples attending three sessions (one weekend day followed by two weekday evenings), or (b) a weekend seminar, which may involve groups of 20-40 couples at a time. There is evidence that the weekend format can be as effective as the more extended versions (Hahlweg, Markman, Thurmaier, Engl, & Eckert, 1998).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

PREP has been more extensively researched regarding long-term effectiveness than other interventions, with almost all this research focusing on effects with premarital couples. (There is little empirical evidence so far that PREP is effective for longer-married couples, although it is often used with them.) Three years after program participation, PREP couples had higher levels of relationship satisfaction and sexual satisfaction and lower problem intensity than matched control couples (Markman, Floyd, Stanley, & Storaasli, 1988). Four to five years after participation, PREP participants continued to interact more positively and communicate less negatively with each other than both matched control couples and couples who had declined the intervention years earlier (Markman, Renick, Floyd, Stanley, & Clements, 1993). Notably, PREP couples reported fewer instances of physical violence with their spouse than did control couples across three- to five-year follow-ups.

RESOURCES REQUIRED

Training for PREP trainers and all necessary materials are available from PREP Inc. Trainers need not be mental health professionals (Stanley et al., 2001). Training costs roughly $450/individual and $675/couple, which includes basic training materials. Training is conducted at various sites around the world; to host a training session on base, contact PREP Inc. for costs and scheduling.

WHERE TO FIND MORE INFORMATION

PREP Inc.
P.O. Box 102530
Denver, CO 80250
TOLL-FREE: (800) 366-0166
Tel: (303) 759-9931
Fax: (303) 759-4212
Email: info@prepinc.com
URL: www.prepinc.com

Relationship Enhancement (RE)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction	

DESCRIPTION

People who are unable to express their feelings to their partners and/or to listen to and understand their partners' feelings often end up with troubled relationships. The Relationship Enhancement (RE) intervention, first pioneered in the 50's and 60's, was designed to enhance and enrich marital relationships by enabling spouses to communicate empathically.

RE participants are taught how to maximize self-disclosure, as well as how to listen and understand with empathic acceptance. These skills are practiced both during the intervention sessions and at home.

MINIMAL IMPLEMENTATION

In the RE intervention, participants generally attend weekly 2- to 2 ½-hour small-group sessions for 6 to 12 weeks. The intervention is also often offered in a weekend seminar format; however, there is not yet any empirical evidence of the weekend seminar's effectiveness.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Over the past 30 years, many studies have established the effectiveness of the RE intervention (see Accordino & Guerney, 2002, for a comprehensive review). Unlike PREP (see page 35), the long-term effectiveness of RE has not been demonstrated beyond one year after participation. However, compared to PREP, there is stronger evidence that RE can improve the relationships of couples who have been together for several years and/or are already distressed (e.g., Brock & Joanning, 1983; Brooks, 1997; Griffin & Apostal, 1993). In 1985, a study of the evidence for 12 different marital enrichment interventions found that RE was by far the most effective (Giblin, Sprenkle, & Sheehan, 1985). According to this study, the average individual in an RE group does better than 83% of those in a control group.

RESOURCES REQUIRED

Group leaders need not be mental health professionals (Collins, 1977). Training for RE group leaders and all necessary materials are available from the National Institute of Relationship Enhancement (NIRE). Training possibilities include a cost-effective videotaped training activity, with coaching by phone, which was recently developed to train group leaders by distance education. The complete videotaped home study training intervention costs $495, plus shipping and handling.

NIRE
4400 East-West Hwy., Suite 28
Bethesda, MD 20814-4501
TOLL-FREE: (800) 4-FAMILIES
Tel: (301) 986-1479
Fax: (301) 680-3756
Email: info@nire.org
URL: www.nire.org

Couples Coping Enhancement Training (CCET)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction ★ Family Coping	★ Personal Coping

DESCRIPTION

Stress is a fact of life, and couples who have a hard time coping are (a) more likely to have unstable, unsatisfying relationships that deteriorate over time, and (b) at higher risk for divorce (Bodenmann, 1997; Bodenmann & Cina, 1999). Couples Coping Enhancement Training (CCET) is an innovative intervention designed to improve marital relationships by increasing participants' ability to cope with stress — both as individuals and as couples.

Developed in Switzerland less than 10 years ago, CCET includes training in communication skills similar to those that are taught in other interventions (e.g., PREP). However, CCET is unique in that its primary focus is enhancing coping abilities. Couples hear lectures and stories and see videos about stress and coping. They also see role plays showing healthy ways to cope with stress individually and together, and are coached through practical coping and communication exercises.

MINIMAL IMPLEMENTATION

In the studies conducted so far, CCET participants met in groups of four to eight couples with one trainer for every two couples. (The developers are currently experimenting with more cost-effective formats.) The workshop typically takes place over a weekend (Friday evening to Sunday evening), lasting a total of 18 hours.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Notably, research on CCET has involved couples who had been together for 1 to 33 years (the average was about 14), not just newlyweds or young couples. Six months after participation, CCET couples were arguing less often than control couples (Bodenmann, Widmer, & Cina, 1999). After one year, CCET couples were more likely to report increases in marital quality and satisfaction, as well as in their problem-solving and coping abilities (Bodenmann, Charvoz, Cina, & Widmer, 2001). Even after two years, intervention participants reported using more healthy and fewer dysfunctional coping strategies than controls (Bodenmann, Perrez, Cina, & Widmer, 2002).

RESOURCES REQUIRED

The manual necessary to train CCET trainers should be available in English by the end of 2003. All trainers in the studies discussed above were psychology students or mental health professionals; however, research is currently underway utilizing clergy and other paraprofessionals as trainers.

Institute for Family Research and Counseling
Av. de la Gare 1
CH-1700 Fribourg
SWITZERLAND
Tel: +41 (0)26/300 73 60
Email: institut-famille@unifr.ch
URL: http://www.unifr.ch/iff/alt/e/indexen.html

Triple P (see page 60)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Relationship Satisfaction ★ Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depressive Symptoms (Levels 4 & 5 only) ★ Personal Coping ★ Anxiety (Levels 4 & 5 only)

Couple CARE

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction	

DESCRIPTION

Originally developed in Australia, Couple CARE is a self-directed relationship education activity designed to help couples effectively strengthen their relationships by means of evidence-based relationship education. It focuses more than traditional, skills-based relationship education programs (e.g., PREP) do on relationship self-regulation, and less on universal prescriptions for specific skills. Couple CARE can enrich each couple's relationship by assisting them to do the following:

- Assess relationship strengths and weaknesses
- Define the relationship they want
- Develop key relationship skills
- Identify individual actions to strengthen their relationship

Each unit of the activity begins by having the couple watch a videotape/DVD presentation that introduces important ideas about successful relationships and demonstrates key relationship skills. They then complete individual and couple activities from their Couple CARE guidebooks. They are supported throughout the process by periodic telephone contact with a professional relationship educator, who (a) clarifies any concepts with which the couple may be struggling, and (b) helps the couple to identify and implement self-change objectives.

MINIMAL IMPLEMENTATION

Couple CARE is uniquely designed to be completed by the couple at home. The couple progresses on their own through 6 separate units. Following each unit, their work is briefly reviewed by phone with their relationship educator.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Couple CARE has been empirically evaluated as both a face-to-face intervention (Halford, Sanders, & Behrens, 2001) and a flexible delivery relationship education activity (Halford, Moore, Wilson, Farrugia, & Dyer, 2004). Participant couples in both formats demonstrated significant gains in relationship quality, as compared to control groups. Couples at relatively high risk for developing relationship difficulties were helped more by the face-to-face sessions than were lower-risk couples, with significant effects still in evidence at 4-year follow-up. The long-term effects of the flexible delivery format have not yet been reported in the literature.

RESOURCES REQUIRED

Couple CARE is designed to be implemented by lay or clergy professional relationship educators. No specific training is necessary, other than that contained in the Educator's

Manual. An Educator Kit containing two Couple Guidebooks, the Couple CARE DVD, and an Educator's Manual costs AU$137.00 (approximately US$103 as of 5/24/06), including shipping. Once an Educator Kit has been purchased, the educator may buy more Couple Guidebooks and DVDs for distribution and/or loaning to participating couples. (See http://www.couplecare.info/CcarePurchase.htm for pricing.)

WHERE TO FIND MORE INFORMATION

Email: info@australianacademicpress.com.au
URL: http://www.couplecare.info/

RELATE

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction	

DESCRIPTION

Historically, most interventions targeting marital relationships have primarily involved skills training; however, a second general approach to relationship education has developed in recent years – namely, the use of relationship inventories (Halford, 2004). RELATionship Evaluation (RELATE; Busby, Holman, & Taniguchi, 2001) is a science-based relationship evaluation instrument that was developed following a review of over 50 years of research on marital relationships. It was designed to assess the 4 major contexts in which a relationship exists – the culture, the family, the couple, and the individual – and to provide an individual or couple with organized feedback on their responses. The objective is to stimulate productive, satisfaction-enhancing discussion by highlighting similarities and differences between the individuals in the relationship.

RELATE is entirely Internet-based and takes about 40 minutes to complete. It consists of 276 questions that cover a broad range of factors known to predict later relationship quality and satisfaction (Busby et al., 2001); many of the questions ask the respondent to provide ratings of characteristics, beliefs, values, strengths, and weaknesses for both self and partner. Once one or, preferably, both members of a couple have finished the evaluation, they are immediately provided with an 11-page report that uses both text and full-color graphs to summarize both parties' responses. The report does not attempt to make specific predictions as to whether the relationship will last, nor does it tell the couple that they have to discuss and/or work on particular issues if they want to be happy in their relationship. Rather it simply clarifies and organizes their perceptions of themselves, each other, and their relationship so that the couple can make their own informed decisions as to which areas may be most beneficial to address.

MINIMAL IMPLEMENTATION

While the RELATE instrument may be completed by one member of a couple (or by someone who is not presently in a relationship), the resulting report is likely to be most useful if completed by both members of a couple. Each can do so on the Internet at any time.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

In a recent study, relative to a wait-list control, premarital couples who completed RELATE demonstrated high consumer satisfaction and moderate increases in relationship quality up to 60 days post-completion (Larson, Vatter, Galbraith, Holman, & Stahmann, 2006). Although those couples who interpreted their RELATE Reports on their own showed significant gains, brief (2 hr.) therapist assistance in interpreting the reports provided a significant additional benefit.

NOTE: While the possibility that administration of RELATE effects long-term improvements in relationship quality has not yet been investigated, the available data do suggest that there may be at least short-term benefits. It is not indicated for couples who already have significant relationship problems, and should therefore not be implemented alone. Rather, we recommend it be used as an early-stage part of a prevention/intervention system that also includes a relationship skills training course (e.g., PREP, CCET) to which participants with problematic relationships can be referred.

RESOURCES REQUIRED

RELATE is designed to be completed and used without any specific training. The cost to consumers for a single administration (and the subsequent report) is $10 per person, or $20 per couple. However, counselors, therapists, educators, and clergy can obtain professional accounts entitling them to purchase and distribute virtual "tokens," each of which allows an individual to complete the assessment, at a cost of $5 per token ($10 per couple). Further discounts are available to bases desiring to purchase large numbers of tokens in bulk, with 500+ tokens costing $4 each and 2500+ costing $3 each. No specific training is necessary for professional therapists to assist participants in interpreting their reports.

WHERE TO FIND MORE INFORMATION

RELATE Institute
P.O. Box 25391
Provo, UT 84602-5391
Tel: (801) 422-4359
Fax: (801) 422-0225
Email: Beforeforever@byu.edu
URL: https://www.relate-institute.org/Default.aspx

Relationship Satisfaction References

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Relationship Enhancement (RE)

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Couples Coping Enhancement Training (CCET)

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Couple CARE

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RELATE

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Family Coping

Introduction

Every family experiences stress in one form or another. However, the stressful lifestyle of modern military families is almost beyond compare (see Hunter, 1982). As (Black (1993, p. 273) points out:

> Life stressors faced by military families include frequent moves, the potential of being deployed into hostile environments,…the threat that their loved ones may be killed or wounded in combat or military accidents,…frequent periods of family separation, geographic isolation from extended-family support systems, low pay, young age as compared to the general population, and a high incidence of young children living in the home. Each stressor might be adequately handled by families when dealt with separately, but military families often must deal with them as an aggregate.

It should also be noted that these stressors — difficult enough to deal with on their own — can create or contribute to relationship problems within families, which in turn create more stress. Given such potential for stressful circumstances and events in military family life, it is essential that service members and their families possess the ability to cope well during difficult times — both as individuals (see page 95) and as family units. The interventions listed in this section have been shown to help couples and/or families work together to overcome life's many challenges. While all three programs teach skills that are applicable to many kinds of stressful life events, one (CCET) has a special focus on coping as a couple, while the others are designed to improve the coping abilities of families with young children.

Items in 2003 AF Community Assessment	Item #s
1. Family works together as a team	M5a
2. Family keeps a positive perspective during tough times	M5b
3. Family has good problem-solving abilities	M5

Activities/Interventions
1-2-3 Magic
Incredible Years ADVANCE
Triple P
Couples Coping Enhancement Training (CCET)

1-2-3 Magic (Ages 2-12)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems ★ Family Coping	

DESCRIPTION

1-2-3 Magic is a brief, videotape-based parent training intervention designed to reduce patterns of conflict between parents and children; replace harsh discipline with gentle yet effective strategies; and reduce child behavior problems. Participants learn how to manage difficult behavior, including limit testing, without arguing, yelling, or spanking.

The 1-2-3 Magic videotape demonstrates positive and negative parenting strategies, as well as methods of self-control and techniques for overcoming child resistance to discipline. Group leaders use the video to help teach new skills and facilitate group discussion and problem solving. Together, leaders and participants explore effective strategies of childrearing.

MINIMAL IMPLEMENTATION

Groups of 7-8 parents meet with a program facilitator for 3 weekly, 2-hour sessions, plus one 2-hour booster session a month later.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

In a large study conducted in Canada (Bradley, et al., 2003), parents of hard-to-manage 3- and 4-year-olds participated in the 1-2-3 Magic program. All group facilitators were trained staff members of community agencies. Program participants reported significant reductions in negative discipline and increases in positive parenting behavior. They also reported that their children were happier, more compliant, and less difficult. A one-year follow-up with a small subsample of participants suggested that the effects of program participation may last over time; however, more and better long-term research is needed.

RESOURCES REQUIRED

At least one 1-2-3 Magic videotape per site (cost: $39.95), plus a VCR in which to play it; at least one manual for group facilitators (cost: $139); 1-2-3 Magic books for facilitators and participants (cost: $14.95 each); and participant booklets for the parents in the groups (cost: $95). Health professionals can train themselves in the intervention using the facilitator manual. Staff members of community

agencies can also act as group leaders, but should be trained by a health professional. A brief manual for conducting such training is available from Dr. Susan Bradley (see below). Otherwise, all necessary videos, manuals, books, and handouts are available from ParentMagic, Inc.

WHERE TO FIND MORE INFORMATION

ParentMagic, Inc.
800 Roosevelt Road, B-309
Glen Ellyn, IL 60137
Tel: 1-800-442-4453
Fax: 1-800-635-8301
Email: custcare@parent-magic.com
URL: www.parent-magic.com

Training manual for community agency staff:

Susan J. Bradley, M.D.
Dept. of Psychiatry
Hospital for Sick Children
555 University Ave.
Toronto, Ontario
CANADA M5G 1X8
Email: susan.bradley@sickkids.ca

Incredible Years ADVANCE (Ages 3-8)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Family Coping	

DESCRIPTION

Incredible Years ADVANCE is a videotape-based parent training series for parents of 3-8 year olds. (This was the age range in the validation study; however, the Incredible Years website states that the intervention is suitable for use with parents of 4-10-year olds). This intervention was designed to supplement the Incredible Years BASIC intervention (see page 65). The ADVANCE series builds on the BASIC intervention by focusing on parents' interpersonal issues, especially those related to family coping. The subjects covered in the intervention include effective communication and problem solving skills, anger management, ways to give and get support, and teaching problem solving skills to children.

The ADVANCE videotapes contain over 2 ½ hours of brief scenes showing parents interacting with each other and/or with their children. Group leaders use these scenes to help teach new skills and facilitate group discussion and problem solving. Parents discuss the principles taught and practice the skills through role-playing and home practice assignments.

MINIMAL IMPLEMENTATION

The ADVANCE series is intended to be implemented with parents who have already completed an Incredible Years BASIC group intervention. Participants meet in groups of 10-14 parents; the ADVANCE intervention can be completed in 8 to 10 weekly, 2-hour sessions. Typically, only the primary caregiving parent attends the sessions. Although the ADVANCE intervention could theoretically be self-administered, there is as yet no evidence that it is effective in any other than a group format.

It should be noted that participating parents rate this intervention as extremely useful and express high consumer satisfaction. In fact, of 38 families randomly assigned to attend the ADVANCE intervention (after already having attended 10-12 weekly 2-hour BASIC sessions), only one family dropped out of the intervention (Webster-Stratton, 1994). All of the remaining families attended over two-thirds of the ADVANCE sessions, with most attending over 90%.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

In 1994, Webster-Stratton randomly assigned parents to receive both BASIC and ADVANCE training, while some parents attended only the BASIC intervention. Compared to BASIC-only parents, mothers and fathers who also attended the ADVANCE groups demonstrated the following:

- More positive communication with each other
- Better problem-solving skills

- Children who were better problem solvers
- Greater ability to work as a team
- Higher consumer satisfaction

RESOURCES REQUIRED

At least one set of Incredible Years ADVANCE videotapes per site (cost: $775 plus shipping and handling; multiple sets can be ordered at a discount) per site, a VCR in which to play them, and preferably a blackboard or easel and pad for the group leader to use. (It may also be possible to obtain permission to broadcast the Incredible Years videotapes to the base community.) All intervention-specific resources — including group leader training, videos, manuals, and handouts — are available from Incredible Years. Introductory training for group leaders lasts three days. These training workshops are offered regularly in Seattle (cost: $400/person for registration, $30/person for training materials, plus travel, lodging, and meals), and certified Incredible Years trainers are also available to go on-site to train leaders if there are a minimum of 15 participants (cost: $1300/day trainer fee for 3 days, $650 half-day travel fee, plus trainer's travel, lodging, and meals, as well as $30/participant for training materials).

WHERE TO FIND MORE INFORMATION

Incredible Years
1411 8th Ave. West
Seattle, WA 98119
Tel: (206) 285-7565
TOLL-FREE: (888) 506-3562
Email: incredibleyears@seanet.com
URL: www.incredibleyears.com

Triple P (see page 60)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Relationship Satisfaction ★ Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depressive Symptoms (Levels 4 & 5 only) ★ Personal Coping ★ Anxiety (Levels 4 & 5 only)

Couples Coping Enhancement Training (CCET) (see page 39)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction ★ Family Coping	★ Personal Coping

Family Coping References

Introduction

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1-2-3 Magic (Ages 2-12)

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Incredible Years ADVANCE (Ages 3-8)

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62,* 583-593.

Parent-Child Relationships

Introduction

As with couple relationships, satisfaction with parent-child relationships is viewed as an indicator of relationship quality. However, when it comes to improving the relationship, parenting satisfaction — like couple satisfaction — is rarely (if ever) a direct target of change. Parenting satisfaction is closely associated with levels of behavior problems in children and with how capably parents are able to manage the problems that occur (Coleman & Karraker, 2000; Johnston & Mash, 1989; Kurdek, 1998), and it is these factors that are usually the targets of parenting interventions.

Dozens of different interventions have been designed to reduce child behavior problems and enhance parents' ability to handle their children. However, many of these interventions have not been empirically validated and/or would not be feasible or practical in the context of NORTH STAR. In this section, we present six interventions that both (a) have good evidence that they can improve parenting abilities and reduce or prevent child behavior problems, and (b) could be cost-effectively and universally implemented by an Air Force base. Two of the interventions (i.e., Family Thriving Program, Triple P Levels 4 & 5) have also been shown to impact other risk factors targeted by NORTH STAR (e.g., Depression, Perceived Personal and Family Coping). Each of the interventions was designed for parents of children within a different age range, and all age ranges from birth to 18 years old are covered by at least one of the interventions.

Items in 2003 AF Community Assessment	Item #s
1. Satisfaction with overall relationship with kids	N7

Activities/Interventions
1-2-3 Magic
Family Thriving Program
Triple P
Incredible Years BASIC
Guiding Good Choices
Parenting Wisely
RETHINK

1-2-3 Magic (Ages 2-12) (see page 50)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems ★ Family Coping	

Family Thriving Program (Ages birth-1)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships	★ Depressive Symptoms

DESCRIPTION

Many communities have home visitation programs that are intended to help and support parents — especially mothers — of new infants, and to enhance family functioning and child health. The Family Thriving Program is a brief, innovative feature designed to be incorporated into and increase the positive impact of such programs.

During the cognitive appraisal discussions, parents are asked for examples of caregiving problems they may be having. They are helped to think through the possible reasons for a specific problem and to design a strategic plan for solving the problem in the future. The success of the chosen strategy is discussed at the next visit, and the plan is modified as needed. "The goal of the program is to give parents repeated experience in finding new ways (directed away from self- or child-blame) of explaining problems and in finding new ways of resolving those problems" (Bugental et al., 2002, p. 247).

MINIMAL IMPLEMENTATION

The cognitive appraisal discussion is quite brief, and is usually to be conducted at the start of each home visit. In the study evaluating the program, the goal was to visit each family 20 times during the first year of the infant's life; the average number of visits actually completed per family was 17.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Although this program is quite new, the evidence for it so far is quite impressive (Bugental et al., 2002). In the study, moderately distressed families were randomly assigned to receive either (a) no home visits, (b) a home visitation program based on the well-known Hawaii Healthy Start program (Breakey & Pratt, 1991; Mitchel-Bond & Cohn-Donnelly, 1993), or (c) the same home visitation program "enhanced" with the cognitive appraisal component. While the "unenhanced" home visitation program did lead to improved child health, it did not seem to affect family functioning. The addition of the cognitive appraisal component, however, led to improved parent-child relationships, healthier ways of parental thinking about caregiving problems, less harsh parenting, and decreased maternal depression. These effects were especially strong in those families where the infant was medically at-risk (i.e., had low Apgar scores or was premature). In fact, the percentage of mothers who reported physically abusing their infants during the first year was 26% in the no-visit group and 23% in the "unenhanced" home visitation group, but only *4%* in the group who received home visits with the additional cognitive appraisal component.

RESOURCES REQUIRED

The home visitors employed in the program evaluation were paraprofessionals who were supervised by a licensed clinical social worker. Training materials for the Family

Thriving Program should be available in 2003; for more information, contact the program developer (see below).

WHERE TO FIND MORE INFORMATION

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Triple P (Ages birth-12)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Relationship Satisfaction ★ Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depressive Symptoms (Levels 4 & 5 only) ★ Personal Coping ★ Anxiety (Levels 4 & 5 only)

DESCRIPTION

Triple P ("Positive Parenting Program") is a multi-level family support strategy that aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents.

Originally developed in Australia, Triple P was designed around the idea that parents have differing needs and desires regarding the type, intensity and mode of assistance that they may require. The Triple P system is designed to maximize efficiency, contain costs, and ensure that the program has wide reach in the community. Thus, Triple P consists of five possible levels of intervention for parents of children from birth to age 12. The five levels are of increasing intensity, as described below. Families can enter the Triple P system of intervention at any level. The system does not require families to progress from the least to most intensive level of intervention, although this may occur. Having completed one level of Triple P does not mean a particular family cannot complete another, and some families should certainly be encouraged to do so.

Level 1: A community-wide, multimedia parent information campaign. Goals include promoting awareness of parenting issues and normalizing participation in parenting programs such as Triple P.

Level 2: A very brief, 1- or 2-session primary care intervention for parents of children with mild behavior problems. Parents receive specific advice on how to solve common child developmental issues (e.g., potty training) and minor child behavior problems (e.g., bedtime problems).

Level 3: A brief primary care program for parents of children with mild to moderate behavior difficulties. The program combines advice with active skills training as required to teach parents to manage a discrete child problem behavior (e.g. tantrums, fighting with siblings).

Level 4: A broadly focused parenting program for parents who want or need intensive training in positive parenting skills (often, these are parents of children with more severe behavior problems). Parenting skills are taught and practiced across a range of target behaviors, settings, and children.

Level 5: An intensive, individually-tailored program for families where parenting difficulties are complicated by other sources of family distress (e.g., relationship conflict, parental depression, and/or high levels of stress). Possible program elements include practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills.

MINIMAL IMPLEMENTATION

Bases implementing Triple P as part of NORTH STAR may choose to apply any one or any combination of the five levels. Implementation by level involves the following:

Level 1: Community-wide use of print and electronic media and other health promotion strategies. May include some contact with professional staff (e.g., via telephone).

Level 2: Guidance with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies. May involve either (a) about 20 minutes (total over 2 sessions) of face-to-face or telephone contact with a primary care service provider or (b) a 60-90 minute seminar. Level 2 providers may come from maternal and child health services, family health care, childcare centers, kindergartens, preschools, schools, and/or other community agencies that offer parent support.

Level 3: About 80 minutes (total over four sessions) of either face-to-face or telephone contact with a primary care service provider. Same potential providers as Level 2.

Level 4: About 10 hours (total over 8-10 sessions). Possible formats include individual, group (groups usually consist of 10-12 parents), or self-directed (with or without telephone assistance) options.

Level 5: Up to 11 face-to-face, individualized sessions lasting 40-90 minutes each.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

All five levels of Triple P are being rigorously validated (for reviews see Sanders, 1999; Sanders, Turner, & Markie-Dadds, 2002). In general, all five levels have been found to reduce child behavior problems, increase parents' sense of competence, and improve parent-child relationships. As might be expected, families who participated in more intense versions of the program generally tended to see more dramatic results. In addition, the two highest levels (i.e., 4 and 5) of Triple P have demonstrated the following effects:

- Reduced mothers' depression
- Reduced mothers' and children's anxiety
- Improved children's self-esteem

- Reduced parental stress
- Reduced marital conflict and increased marital satisfaction
- Improved parents' perceived ability to work together as a team

RESOURCES REQUIRED

Required resources will vary greatly depending on the level(s) to be implemented. However, the materials and training necessary for any and all of the five levels are available from Triple P International or Triple P America. Training courses are conducted either at Triple P America headquarters in South Carolina or on-site and are available for levels 2 & 3 (combined) and levels 4 & 5 (combined or separate). Each course is presented to up to 22 trainees and lasts 3-6 days total, with the final day of training scheduled 6-8 weeks following completion of the rest of the course. Training ranges in price from about $500 to $1500 per participant, plus travel, lodging, and materials.

WHERE TO FIND MORE INFORMATION

Triple P International
Email: info@triplep.net
URL: www.triplep.net

For training and materials in the U.S., contact:

Triple P America
4840 Forest Drive #308
Columbia, SC 29206
Tel: (803) 787-9944
Email: triplepa@bellsouth.net
URL: www.triplep-america.com

Common Sense Parenting (Ages 2-17)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Parents' Sense of Competence ★ Child Externalizing Behavior Problems (defiance, aggression) ★ Total Child Behavior Problems (may include social withdrawal, anxiety, and/or depression) ★ Total Child Abuse Potential (may include rigid expectations for child behavior)	

DESCRIPTION

Common Sense Parenting (CSP) is a parent training intervention designed to teach practical child management skills to parents. Skills taught during the course of the intervention include:

- Developing family rules;
- Using consequences to correct negative behaviors;
- Using praise to teach and encourage positive behaviors;
- Reaching goals with charts and contracts;
- Thinking ahead to prevent problems;
- Teaching children to remain calm in difficult situations;
- Teaching children to make decisions and solve problems.

During training sessions, CSP trainers teach these parenting skills by means of presentations, discussions, videotaped examples, live role-plays, and homework assignments.

MINIMAL IMPLEMENTATION

The original version of CSP includes a 60-minute assessment interview with each parent or set of parents — typically conducted in their homes — plus 8 weekly 2-hour group sessions led by two CSP trainers. An abbreviated version consisting only of 6 weekly 2-

hour group sessions led by one trainer has been found to be equally effective. In either case, individual meetings with trainers may also be made available to parents who need or desire them. Support and follow-up may also include telephone consultations between sessions and/or following completion of the intervention.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Repeated evaluations of CSP (Ruma, Burke, & Thompson, 1996; Thompson, Grow, Ruma, Daly, & Burke, 1993; Thompson, Ruma, Brewster, Besetsney, & Burke, 1997; Thompson, Ruma, Schuchmann, & Burke, 1996) have shown that parents feel more competent and are better problem-solvers after participating in the intervention. Importantly, participants also reported fewer behavior problems with their children; these effects were maintained at 3-month follow-up. In addition, participating parents demonstrated increased satisfaction with family relationships and a significant decrease in child abuse potential. The intervention has been shown to be effective for parents of children of all ages between 2 and 17 and for both middle- and low-income families.

RESOURCES REQUIRED

At a minimum, trainers will need a meeting room, VCR, and television along with the course materials. In the standard CSP intervention, including home visitation, group meetings, and follow-up, it was estimated that the intervention required about 70 hours of staff time to serve 10 families, at a cost of $160 per family. In the abbreviated intervention, staff time was cut down to 30 hours to serve 10 families at a cost of $70 per family (Thompson et al., 1996). Training workshops last for 4 days and are offered at Boys Town in Nebraska or on-site. For the training at Boys Town, the cost is $675 per person.

WHERE TO FIND MORE INFORMATION

Girls and Boys Town National Resource and Training Center
14100 Crawford St.
Boys Town, NE 68010
TOLL-FREE: (800) 545-5771
Fax: 402-498-1500/1501
Email: nrtcmarketing@girlsandboytown.org
URL: http://www.girlsandboystown.org/pros/training/index.asp

Incredible Years BASIC (Ages 3-8)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems (defiance, aggression) ★ Total Child Behavior Problems (may include depression and/or anxiety) ★ Use of Corporal Punishment	

DESCRIPTION

Incredible Years BASIC is a videotape-based parent training intervention designed to improve parent-child relationships, replace harsh, negative parenting strategies with positive strategies, and reduce child conduct problems in families with young children. The validation research was conducted with parents of children aged 3-8; however, two sets of videotapes are currently available — one for parents of children aged 2-7, and one for parents of children aged 5-12. In either video series, the subjects covered include supportive play skills, positive reinforcement skills, nonviolent discipline techniques, and use of natural and logical consequences for child behavior.

The BASIC videotapes consist of over 250 brief scenes showing parents interacting with their children. When the intervention is conducted in group format, group leaders use these scenes to help teach new skills and facilitate group discussion and problem solving. Parents discuss the principles of childrearing and practice the skills through role-playing and home practice assignments.

MINIMAL IMPLEMENTATION

The intervention can be self-administered or offered for groups of 10-14 parents. The intervention generally takes 10-14 weekly, 2-hour sessions for either format.

It should be noted that any difficulties with implementation are most likely to be encountered when trying to get parents to begin the intervention. Those who do begin usually find it very interesting and useful and choose to complete most of the sessions. Thus, it might be productive to offer some kind of incentives for beginning and/or completing the intervention (e.g., door prizes).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Researched in a series of studies with over 600 children, the BASIC intervention has been shown to be effective in significantly improving parent-child interactions and parental attitudes. Participation also decreases parents' use of spanking and reduces child conduct problems (for reviews, see Webster-Stratton, 2001; Webster-Stratton & Hancock, 1999). The effects of the intervention are consistently maintained one to three years after participation. The group discussion version has been found to be somewhat more effective and creates more consumer satisfaction than the self-administered version; however, the self-administered version is more cost-effective (Webster-Stratton, Hollingsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollingsworth, 1988).

RESOURCES REQUIRED

At least one set of Incredible Years BASIC videotapes per site (cost: $1300 for the 2-7-year-old series, $995 for the 5-12-year-old series), plus a VCR in which to play them. Other necessary resources (e.g., blackboards, group leaders) will vary depending on the format in which the intervention is to be presented. (It may be possible to obtain permission to broadcast the Incredible Years videotapes to the base community.) All necessary videos, group leader training, manuals, and handouts are available from Incredible Years. Introductory training for group leaders lasts three days. These training workshops are offered regularly in Seattle (cost: $400/person for registration, $30/person for training materials, plus travel, lodging, and meals), and certified Incredible Years trainers are also available to go on-site to train leaders if there are a minimum of 15 participants (cost: $1300/day trainer fee for 3 days, $650 half-day travel fee, plus trainer's travel, lodging, and meals, as well as $30/participant for training materials).

WHERE TO FIND MORE INFORMATION

Incredible Years
1411 8th Ave. West
Seattle, WA 98119
TOLL-FREE: (888) 506-3562
Tel: (206) 285-7565
Email: incredibleyears@seanet.com
URL: www.incredibleyears.com

Parents Who Care – Guiding Good Choices (ages 9-14)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems (defiance, aggression)	

DESCRIPTION

Formerly known as Preparing for the Drug Free Years, Parents Who Care – Guiding Good Choices (GGC) is a multimedia training activity that promotes healthy, protective parent-child interactions (parent-child bonding and effective child management) and reduces children's risk for early substance use initiation. While GGC is presented as a substance use prevention activity, the target for direct improvement is the parent-child relationship.

Like other parenting activities, GGC helps parents set up clear expectations and rewards for positive behavior. However, this intervention does include a specific focus on the prevention of alcohol and other drug use. Through videotaped scenes, group discussion, and short lectures, group leaders teach ways for parents and children to develop a family position on drug use together. The intervention also provides opportunities for parents and children to learn and practice effective family management skills together.

MINIMAL IMPLEMENTATION

Facilitated by two co-leaders (often past participants) recruited from the community, the intervention consists of five two-hour sessions. Parents meet in groups, and their 9-14-year-old children attend one of the sessions with their parents. Given the proper equipment (e.g., large-screen video projector, public address system), GGC can be effectively conducted with large groups of parents at one time.

DOCUMENTED RESULTS (Empirical Evidence: **Best**

GGC has demonstrated significant positive effects. Participating mothers and fathers interacted more positively and less negatively with their children; they also had more emotionally satisfying parent-child relationships than did nonparticipants. These effects were maintained one year after participation (Kosterman, Hawkins, Spoth, Haggerty, & Zhu, 1997; Redmond, Spoth, Shin, & Lepper, 1999; Spoth, Redmond, & Shin, 1998). The children of intervention participants were also less likely to begin using substances (e.g., alcohol, tobacco, marijuana); those who did use such substances tended to do so less often (Spoth, Redmond, & Shin, 2001).

RESOURCES REQUIRED

VCR, overhead projector, easel & pad. All other materials and training available from the Channing Bete Company (see below). A workshop kit costs $759 plus shipping and

handling; additional parent guides are also available for $7.39-$12.79 each, depending on how many are ordered. Call 1-877-896-8532 for prices on group leader training.

WHERE TO FIND MORE INFORMATION

Developer:

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Social Development Research Group
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Seattle, WA 98115
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Fax: (206) 543-4507
Email: sdrg@u.washington.edu
URL: http://depts.washington.edu/sdrg

For information about materials and training:

Channing Bete Company
One Community Place
South Deerfield, MA 01373-0200
TOLL-FREE: (877) 896-8532
Fax: (800) 499-6464
Email: custsvcs@channing-bete.com
URL: www.channing-bete.com/positiveyouth/pages/FTC/FTC-GGC.html

Parenting Wisely (Ages 8-18)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships ★ Child Externalizing Behavior Problems (defiance, aggression)	

DESCRIPTION

Parenting Wisely (American Teen) is an interactive, video-based CD-ROM program designed to improve the parenting skills of parents of adolescents and pre-adolescents (ages 8-18). Neither previous computer experience nor the ability to read (the computer reads all text aloud) are required.

The computer program prompts parents to choose family scenarios relevant to them. Within the chosen scenario, the parents watch a challenging situation and attempt to resolve the situation by selecting from among three possible problem resolution methods. Both effective and ineffective parenting solutions are depicted for each problem, followed by comprehensive critiques and explanations of the various parenting and communication skills.

MINIMAL IMPLEMENTATION

Parenting Wisely is entirely self-administered, teaches parents how to use itself, and requires no trained staff for its delivery. It is also quite brief; although parents are able to proceed at their own pace and repeat any segment(s) as desired, most take only 2 ½-3 hours total to complete the activity.

Information is available on the factors that have contributed to successful implementation at 93 different agencies (see Gordon & Stanar, in press). For example, the program is more likely to be accessed if it is available in multiple locations within a community. Training is available to show how to generate community support for the intervention and how to add clinical components to the intervention (e.g., brief family consultation, group presentation), if desired.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Several research studies have been conducted on the intervention, and others are currently underway (for review, see Gordon, 2000; many of the reports are available online at www.familyworksinc.com). Good evidence exists that using Parenting Wisely can reduce (pre-)adolescent behavior problems, improve parenting knowledge and skills, and strengthen relationships between (pre-) adolescents and parents.

RESOURCES REQUIRED

The Parenting Wisely intervention is contained on a CD-ROM that is formatted for a personal computer (PC). The PC must have a CD-ROM player and the ability to play video on the computer screen and play sound. Technical assistance from Family Works Inc. is available at no charge. The CD-ROM costs $599, with parent workbooks costing between $6.75 and $9.00 each, depending on how many are ordered.

WHERE TO FIND MORE INFORMATION

Family Works, Inc.
20 East Circle Drive, Suite 190
Athens, Ohio 45701-3751
TOLL-FREE: (866) 234-WISE
Tel: (740) 593-9505
Fax: (541) 482-2829
Email: familyworks@familyworksinc.com
URL: www.familyworksinc.com

RETHINK

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parents' Sense of Competence ★ Inappropriate Expectations for Children's Behavior ★ Use of Corporal Punishment	★ Anger/ Hostility

DESCRIPTION

Anger Management for Parents: The RETHINK Method is a parenting intervention designed to develop anger management skills, improve parent-child interactions, and increase knowledge of child development. Anger management skills taught by the intervention include:

R - Recognize when you are beginning to feel angry, what you are angry about and what the other person might be angry about
E - Empathize with the other person
T - Think about your anger and consider if there is another way to reframe the situation
H - Hear what the other person is saying
I - Integrate compassion, respect and where appropriate, love into your responses
N - Notice how your body tells you that it is feeling angry
K - Keep to the problem at hand

RETHINK facilitators use videotapes and the Program Guide to teach the seven RETHINK skills, plus provide developmental information geared toward the ages of the children whose parents are attending. During each session, parents learn one or two of the skills and then practice them in small groups.

MINIMAL IMPLEMENTATION

The intervention consists of six weekly sessions, lasting about 2 hours each. Parents meet in groups of 10-14. The sessions are facilitated by professionals or paraprofessionals trained in the RETHINK method.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The RETHINK method is relatively new, and only one independent study of its efficacy has been conducted so far (Fetsch, Schultz, & Wahler, 1999). After participating in the RETHINK workshops, parents generally reported experiencing less anger and feeling more in control when they were angry. They also reported using less verbal and physical aggression in dealing with their children than they had previously used. Participants also reported having more age-appropriate expectations of their children and feeling more competent as parents following training. Since a control group was not used in this study, these results must be viewed with caution. However, the changes that were reported were

all consistent with a reduction in risks for child abuse and an increase in factors that enhance family wellness.

RESOURCES REQUIRED

Materials and training are available from the Institute for Mental Health Initiative (IMHI; see below). IMHI offers a two-day training workshop for facilitators, with three half-day follow-up consultations conducted on-site. An abbreviated training is also available. Time and cost for training depends on individual need and is determined through consultation with the intervention developers.

WHERE TO FIND MORE INFORMATION

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Fax: (202) 467-2289
Email: imhi-info@gwumc.edu
URL: www.gwumc.edu/sphhs/imhi/rethink.html

Parenting Newsletters (Ages 0-3+)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships	

DESCRIPTION

Over 20 years ago, Cudaback et al. (1985) reported that 19 State Cooperative Extension Family Life Education Programs were using age-paced newsletters as practical, economical, efficient ways to provide families with valuable child development and parenting information. Since then, the number of states using these newsletters has increased, largely because the recipients report (a) reading them, (b) valuing the information they contain, and (c) parenting more effectively because of them. One of these information series, developed by the University of Wisconsin-Extension, has been empirically validated and therefore merits consideration for implementation as part of the NORTH STAR Initiative.

Parenting the First Year is a 12-issue, eight-page newsletter designed to be sent to parents over the course of their child's first year of life. The newsletters describe the developmental changes parents should be watching for in their children and provide guidelines on how to foster proper child development and respond to parenting challenges. Because information is keyed to the baby's birth month, it reaches parents when they are most ready to use it. Other age-paced newsletters are intended for expecting parents (*Preparing to Parent*), as well as parents of toddlers (*Parenting the Second and Third Year*) and preschoolers (*Parenting the Preschooler*). Age-paced inserts covering other topics (e.g., emergent literacy, child temperament, teaching self-care, grandparents raising grandchildren) are also available.

MINIMAL IMPLEMENTATION

New parents should be sent one *Parenting the First Year* issue, appropriate for the age of their infant, each month during the baby's first year of life. *Preparing to Parent* (8 issues sent during pregnancy) and *Parenting the Second and Third Year* (12 bimonthly issues sent from age 1 to 3) newsletters should be used as well to increase the proportion of the community that can be reached.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Parents throughout Wisconsin receive the newsletter (a) without having to request them, and (b) whether or not they already have children (Riley, 1997). They tend to be well-received and -read; indeed, of those readers responding to an evaluation survey, 70% indicated that two or more people in their households read the newsletters (Riley, Meinhardt, Nelson, Salisbury, & Winnett, 1991). Furthermore, when asked to rate the usefulness to them of seven common sources of parenting information, including the *Parenting the First Year* newsletter, parents rated the newsletter as *very useful* more frequently than any other source – including relatives (e.g., one's own parents) and physicians. Parents who receive the newsletters are less likely than other parents to

believe that physical punishment is necessary to prevent a child from becoming spoiled, and less likely to report actually spanking or slapping their babies (Riley, 1997). Self-reported parenting behavior change is greater in those parents who read more of the articles and those who discuss the newsletter contents more with others (Walker & Riley, 2001).

RESOURCES REQUIRED

A three-year site license for distribution of the *Parenting the First Year* newsletter is available from the University of Wisconsin-Extension (see below). A license costs $600 and authorizes the distributing agency to print and distribute 550 sets of 12 issues each over the course of 3 years; additional sets may be printed and distributed for $1.10 per set. The cost for *Parenting the Second and Third Year* is the same; a license for *Preparing to Parent* costs $600 and allows printing and distribution of 300 sets of 8 issues each over 3 years, with additional sets costing $.80 each. All three licensed newsletter series are also available in Spanish. Other newsletters and inserts (e.g., *Parenting the Preschooler*) may currently be freely printed and distributed.

Other than a distribution license, the only costs for this intervention will be those incurred for printing/copying the newsletters, some staff time to stuff and address envelopes, and postage to any off-base residences.

WHERE TO FIND MORE INFORMATION

Jim Smith
Cooperative Extension Publishing Services
Room 103 Extension Building
432 North Lake Street
Madison, Wisconsin 53706
Tel: (608) 262-2655
Fax: (608) 265-2530
E-mail: jim.smith@uwex.edu
URL: http://www.uwex.edu/ces/flp/parenting/index.html

Parent-Child Relationships References

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Family Thriving Program (Ages birth-1)

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Triple P

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Common Sense Parenting (Ages 2-17)

Ruma, P. R., Burke, R. V., & Thompson, R. W. (1996). Group parent training: Is it effective for children of all ages? *Behavior Therapy, 27,* 159-169.

Thompson, R. W., Grow, C. R., Ruma, P. R., Daly, D. L., & Burke, R. V. (1993). Evaluation of a practical parenting program with middle- and low-income families. *Family Relations, 42,* 21-25.

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Parents Who Care – Guiding Good Choices (ages 9-14)

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RETHINK

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Physical Health

Introduction

Many markers of physical well-being indicate an increasingly unfit country. A national survey conducted in 1999-2000 showed that an estimated 64% of U.S. adults are either overweight or obese, up from 56% in 1988-1994 (Flegal, Carroll, Ogden, & Johnson, 2002). This is perhaps not surprising, as over two-thirds of adult Americans do not exercise on a regular basis, and only 15% engage in the recommended amount of physical activity (Barnes & Schoenborn, 2003; U.S. Department of Health and Human Services, 2000). Likewise, our eating habits leave much to be desired. On average, we eat too much of the wrong kinds of food and not enough of the right kinds. For example, only one-quarter of American adults consume the recommended 5 servings a day of fruits and vegetables (Stables et al., 2002).

If we as a nation do not somehow begin to exercise more and eat properly, our health is highly likely to continue to deteriorate. In addition to its implications for weight control, regular physical activity is associated with many health benefits, including reduced risk of heart disease, stroke, high blood pressure, diabetes, colon cancer, osteoporosis, depression, and *death from any cause* (see Kahn et al., 2002). Those who exercise regularly also feel less anxious and better able to cope with their problems (Moses, Steptoe, Mathews, & Edwards, 1989). Similarly, the consumption of fruits and vegetables is related to better health, reduced risk of many major diseases — especially cancer — and possibly even a delay in the appearance of some of the signs of aging (e.g., skin wrinkles; Hyson, 2002).

Many interventions have been developed with the goal of increasing physical activity and/or fruit and vegetable intake. We present below a selection of activities that have been tested and proven effective in this regard.

Items in 2003 AF Community Assessment	Item #s
1. Healthy diet	H1g
2. Regular physical activity	H1h
3. State of physical health	H2c
4. Satisfaction with physical health	H3
5. Pregnancy	H4

Activities/Interventions
Point-of-Decision Prompts
NoonTime Walkers
5 A Day
Community Gardens

Point-of-Decision Prompts

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Physical Activity

DESCRIPTION

Point-of-decision prompts are simply signs placed near elevators and escalators that encourage people to use nearby stairs. The signs tell people about a potential health benefit from taking the stairs (e.g., weight loss) and/or remind those who want to be more physically active that taking the stairs represents an opportunity to do so.

MINIMAL IMPLEMENTATION

Signs must be created and placed.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

This intervention is simple, but can have powerful effects. Point-of-decision prompts have been tested in various locations, including shopping malls, train and bus stations, and a university library. Across several studies (e.g., Andersen, Franckowiak, Snyder, Bartlett, & Fontaine, 1998; Blamey, Mutrie, & Aitchison, 1995; see Kahn et al., 2002, for a review), posting the signs increased the use of stairs by an average of 54%. Tailoring the prompts by customizing the sign to appeal to specific populations and/or by mentioning specific benefits of stair use appeared make the activity more effective. For example, obese people were more likely to respond to a sign linking stair use to potential weight loss than to a sign listing general health benefits of taking the stairs. A message specifically designed for a black population was also especially effective.

RESOURCES REQUIRED

All that is needed are signs and people to place them in strategic locations. Sample signs created by the state of Maryland can be viewed, ordered, or printed at www.smartstepforward.org/html/stairwell.html.

WHERE TO FIND MORE INFORMATION

Gregory W. Heath, DHSc, MPH
Division of Nutrition & Physical Activity, CDC
Tel: (770) 488-5198
Email: gwh1@cdc.gov

NoonTime Walkers

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Physical Activity ★ Personal Coping ★ Anxiety

DESCRIPTION

The American College of Sports Medicine (ACSM) recommends that to produce increases in fitness and health, adults should engage in at least three 20-30 minute sessions of light to moderate physical activity (e.g., walking) each week (ACSM, 1990). The activity should be just intensive enough to raise heart rates to 60% of age-based estimated maximum (HR_{max}; Moses, Steptoe, Mathews, & Edwards, 1989). Unfortunately, it is estimated that less than 25% of the U.S. adult population exercises at this level (U.S. Department of Health and Human Services, 1991).

The NoonTime Walkers activity was designed to increase participants' physical activity to the recommended level. In order to meet this goal, the intervention utilizes a combination of frequent prompting, self-monitoring, and social support.

MINIMAL IMPLEMENTATION

Participants attend an initial 15-minute training session at which they receive: (a) area walking maps detailing various walking routes with distances noted, (b) handouts on how to enlist a walking partner or begin a walking group, (c) an age-based table of maximum heart rates, and (d) basic strategies for starting (i.e., start slowly and work it into your daily routine). Each participant is also given the goal to walk with at least one partner for at least 20 minutes at least three times each week. For the next three months (or longer, if desired), each participant receives a weekly one-minute telephone call asking simply, "How's your walking activity going?" If the participant has walked, the caller is supportive of the amount of walking accomplished; if the participant has not walked, the caller is supportive of future attempts.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

In the study assessing the intervention's effectiveness (Lombard, Lombard, & Winett, 1995), women were much more likely to participate than men. The simple procedures involved were surprisingly effective at getting the participants to engage in and maintain a regular exercise activity. Of those who received the intervention as described above, 63% were still walking 3 months after the phone calls stopped. Of these walkers, 82% were still meeting the ACSM recommendations of at least 3 exercise sessions a week lasting at least 20 minutes each. These results were as good as those for participants who received highly structured telephone calls, and much better than those who received less frequent calls or no calls at all. The authors hypothesized that the phone calls helped people to form a walking habit, which they were able to maintain on their own once the calls ceased.

Those who engage in the intervention and meet the ACSM minimum recommendations are likely to see tremendous benefits. In one particularly well-designed study (Moses, Steptoe, Mathews, & Edwards, 1989), it was shown that 10 weeks of moderate aerobic activity (at 60% HR_{max}) significantly increased participants' perceived and actual level of fitness, decreased their anxiety, and improved their perceived coping ability. Ten weeks of high-level aerobic exercise (at 70-75% HR_{max}) increased physical fitness somewhat more than did moderate exercise, but had no effect on either anxiety or perceived coping.

RESOURCES REQUIRED

Handouts, plus someone to conduct the initial training session and to make the weekly telephone calls are the only required resources. Handouts are available from the intervention developer or the Weight-control Information Network (see below); for an age-based maximum heart rate table, go to www.health.co.delaware.oh.us/dawg.htm.

WHERE TO FIND MORE INFORMATION

Intervention developer:

David N. Lombard, Ph.D.
3242 Mallard Cove La.
Fort Wayne, IN 46804-2883
Tel: (260) 459-2900
Email: drlombard@comcast.net

Or contact:

Weight-control Information Network
1 Win Way
Bethesda, MD 20892-3665
TOLL-FREE: (877) 946-4627
Tel: (202) 828-1025
Fax: (202) 828-1028
Email: win@info.niddk.nih.gov
URL: http://win.niddk.nih.gov/index.htm

5 A Day

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Healthy Diet

DESCRIPTION

The 5 A Day for Better Health Program is a joint effort of the National Cancer Institute, the Produce for Better Health Foundation, plus numerous other governmental, nonprofit, and corporate-sponsored organizations. Its message to Americans is simple: Eat 5 or more servings of fruits and vegetables every day for better health.

Since 1991, states, communities, and organizations have utilized virtually every channel imaginable to distribute this message (Havas et al., 1995), including:

- Mass media (e.g., television, radio, magazine and newspaper articles)
- Schools (e.g., changes in food service environment, workshops, classroom curricula)
- Community centers (e.g., periodic mailings, festivals)
- Churches (e.g., nutrition messages, contests and demonstrations, planting fruit trees and vegetable gardens)
- Worksites (e.g., lectures, special events, taste testing, discussion groups, contests, information distribution via brochures, videos, posters in cafeterias, etc.)
- WIC sites (e.g., written materials, visual reminders)
- Families (e.g., written learn-at-home programs for families; having children contribute illustrated recipes of foods containing fruits and vegetables, which are compiled into a cookbook and distributed)
- Point-of-purchase bulletins (e.g., signs in supermarkets)

MINIMAL IMPLEMENTATION

Due to the variety of ways in which this program can be implemented, it is virtually impossible to define a "minimum." However, placing one poster extolling the virtues of fruit and vegetable consumption would not be considered sufficient. Please contact the Air Force program coordinator (see below) to determine what methods are likely to be most practical and effective for your base.

DOCUMENTED RESULTS (Empirical Evidence: **Best**

Virtually all of the evidence collected since the program began in 1991 has demonstrated that it has improved public awareness of the health benefits of eating fruits and vegetables, and has significantly increased program recipients' daily fruit and vegetable consumption (for a review, see National Cancer Institute, 2001). In general, the more intensively the program is implemented, the stronger the effects. For example, one study (Sorensen et al., 1999) found that a series of interventions involving worksites and families increased fruit and vegetable intake by almost three times as much as did the worksite interventions alone.

RESOURCES REQUIRED

Specific resources will vary greatly depending on the ways in which the program is to be implemented. Many materials (e.g., program tips, media packages, recipes) are available free of charge through the National Cancer Institute's 5 A Day website (see below).

WHERE TO FIND MORE INFORMATION

National Cancer Institute
URL: www.5aday.gov

Air Force 5 A Day Coordinators:

Maureen Harback, Major, USAFR, BSC
Chief, Community Nutrition
AFMOA/SGZP
110 Luke Ave, Room 405
Bolling AFB, DC 20332-7050
Tel: (202) 767-4264
Fax: (202) 404-8089
Email: maureen.harback@pentagon.af.mil

Community Gardens (see page 13)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Unity ★ Support from Neighbors			★ Healthy Diet ★ Personal Coping

Physical Health References

Introduction

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Point of Decision Prompts

Anderson, R. E., Franckowiak, S. C, Snyder, J., Bartlett, S. J., & Fontaine, K. R. (1998). Can inexpensive signs encourage the use of stairs? Results from a community intervention. *Annals of Internal Medicine, 129,* 363-369.

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NoonTime Walkers

Lombard, D. N., Lombard, T. N., and Winett, R. A. (1995). Walking to meet health guidelines: The effect of prompting frequency and prompt structure. *Health Psychology*, 2, 164-170.

Moses, J., Steptoe, A., Mathews, A., & Edwards, S. (1989). The effects of exercise training on mental well-being in the normal population: A controlled trial. *Journal of Psychosomatic Research, 33,* 47-61.

5 A Day

Havas, S., Heimendinger, J., Damron, D., Nicklas, T. A., Cowan, A., Beresford, S. A. A., et al. (1995). 5-a-day for better health — 9 community research projects to increase fruit and vegetable consumption. Public Health Reports, 110, 68-79.

National Cancer Institute. (2001). *5 A Day for Better Health Program monograph.* Retrieved September 12, 2003, from http://www.5aday.gov/pdf/masimaxmonograph.pdf

Sorensen, G., Stoddard, A., Peterson, K., Cohen, N., Hunt, M. K., Stein, E., et al. (1999). Increasing fruit and vegetable consumption through worksites and families in the Treatwell 5-a-Day study. American Journal of Public Health, 89, 54-60.

Personal Finances

Introduction

Financial stress is an extremely widespread problem among American families today. Our society tends to measure financial success not by how much wealth we accumulate, but rather by how much we spend and what we own (Kottler, 1999). Consumer debt levels continue to rise, already-low personal saving rates are in further decline, and household "debt-service burden" — the proportion of disposable income that must be used to make minimum scheduled payments on mortgage and consumer debt — is at near-record levels (Braunstein & Welch, 2002). Perhaps not surprisingly, over 1.5 million Americans filed for personal bankruptcy *in 2002 alone*, more than triple the almost one-half million who filed in 1987 (American Bankruptcy Institute, n.d.).

Understandably, financial difficulties can be a major stressor, wreaking havoc on individuals' mental health and marital relationships. Personal financial problems have also been linked with reduced employee productivity (Joo & Grable, 2000). It has been conservatively estimated that 15% of all employees in the United States are experiencing stress from poor personal financial situations and behaviors to the extent that it negatively affect the ability to do their jobs — and the proportion may be as high as 40% or 50% in some organizations (Garman, Leech, & Grable, 1996).

In light of all of this, many employers have begun offering financial education and/or services (e.g., retirement planning, debt counseling) to their employees, and the employees appreciate it. Indeed, up to 85% of all employees want to get financial information where they work (Gorbach, 1997). In general, workplace financial education has great potential (Employee Benefits Research Institute, 1998); however, there are many different types of education and services that can be offered, and few have been empirically evaluated. The interventions described in this chapter, in contrast, have been tested and shown to effectively improve people's financial behaviors.

Items in 2003 AF Community Assessment	Item #s
1. Not earning enough to meet needs	J1, J2, J3
2. Find it difficult to pay bills due to lack of money	J1, J2
3. Bounced checks	J2
4. Missed payments/made payments late	J2
5. Been contacted by bill collector	J2
6. Had something repossessed or utilities shut off	J2
7. Declared bankruptcy	J2

Activities/Interventions
EDSA Group© Workshops (Youth)
EDSA Group® Workshops
Self-Control Training
NEFE High School Financial Planning

EDSA Group Workshops (Youth)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Finances

DESCRIPTION

The National Endowment for Financial Education® (NEFE) is a non-profit foundation whose mission is to help all Americans gain the information and obtain the skills necessary to take control of their personal finances. Focusing many of its efforts on increasing the financial literacy of our nation's youth, NEFE recently developed and evaluated the High School Financial Planning Program (HSFPP®), which consists of six basic modules:

- *Financial Planning: Your Roadmap,* an introduction to the financial planning process
- *Careers: Labor You Love,* on the relationship between career/work factors and earning potential
- *Budget: Don't Go Broke,* about developing a personal spending/savings plan
- *Savings and Investments: Your Money at Work,* on the importance of saving and investing and the benefits of using the time value of money
- *Managing Credit: Buy Now, Pay Later,* about using and managing credit effectively
- *Insurance: Your Protection,* about how to protect assets by means of appropriate insurance

MINIMAL IMPLEMENTATION

The entire HSFPP program can take as little as 10 hours to present. Modules may be presented over the course of anywhere between two or three weeks to several months.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

The HSFPP has been evaluated in a national sample of 4,107 high school students, 94% of whose teachers used at least four modules in their classrooms (Danes, Huddleston-Casas, & Boyce, 1999). On average, participants reported significant improvements in financial knowledge, financial management behaviors, and financial self-confidence following the program. For example, 50% of participants reported knowing more about the cost of buying on credit; 49% knew more about investments. About a third reported gains in setting and meeting financial goals, tracking expenses, and saving. Forty-two percent said they felt more confident in their ability to make decisions involving money. All results were maintained three months after the program ended.

RESOURCES REQUIRED

A room in which to conduct the class is needed, along with someone who has learned to present the modules. All English-language materials for instructors and participants are available free of charge from NEFE (see below); manuals can also be downloaded and printed in Spanish. NEFE also offers a web-based training program for instructors, as well as online support sites for both instructors and students.

WHERE TO FIND MORE INFORMATION

National Endowment For Financial Education
NEFE High School Financial Planning Program
5299 DTC Blvd., Suite 1300
Greenwood Village, CO 80111
Tel: (303) 224-3511
Fax: (303) 220-0838
Email: eas@nefe.org
URL: www.nefe.org

EDSA Group Workshops

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Finances

DESCRIPTION

The EDSA Group is a Louisiana-based financial education company that specializes in teaching people to make informed decisions about their personal finances and employer-sponsored benefit plans. Many such companies exist; however, unlike most, the EDSA Group's workshops have been empirically validated. Several workshops are available; the workshops offered to participants in the validation study were as follows:

- *Money Basics,* focusing on comprehensive financial planning topics.
- *Retiring Easy,* a pre-retirement workshop for those who are 5 to 15 years away from retirement.
- *Magic of 401(k),* which teaches employees how to use their retirement plans to effectively meet retirement income needs.
- *Planning Plus,* one-on-one counseling at the employer's site that allows personalized consultation for those who have attended a company-sponsored workshop.

MINIMAL IMPLEMENTATION

EDSA Group workshops vary in length — *Money Basics* lasts for 6 hours, *Retiring Easy* takes 3 hours to present, and *Magic of 401(k)* is a 2-hour course.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

Several of the most well-known researchers in the field of workplace financial education conducted a study of the effects of EDSA Group workshops at a Southeastern chemical production plant where the workshops had been offered repeatedly over the course of three years (Garman, Kim, Kratzer, Brunson, & Joo, 1999). About half of those participating in the study had attended at least one workshop with most of attending only one or two of the workshops offered, with *Money Basics* being the most popular course.

When compared to non-participants, workshop participants reported that they (a) had greater satisfaction with the amount of money they were able to save, (b) felt more confident in their ability to save for a comfortable retirement, (c) were more likely to set money aside for savings, and (d) were more likely to set money away for retirement. In contrast, compared to participants, non-participants were more likely to (a) be worried about being able to pay monthly expenses, (b) be worried about the amount of money they owed, (c) have had to cut living expenses, and (d) have reached the maximum limit on a credit card. Workshop participants reported having made several positive changes in their personal financial behavior as a result of the information they had received.

The results of this study must be interpreted with some caution, as participation was voluntary, and those with poorer financial habits may have elected not to participate. However, by far the most common reason given for nonparticipation was "the time conflicted with my schedule." Also, the opportunity to attend more financial education workshops was desired by 80% of participants and non-participants alike.

RESOURCES REQUIRED

A room in which to conduct the workshops is needed, along with someone who has been trained to present them. The EDSA Group offers a nationwide network of rigorously trained financial professionals plus traveling instructors; their fees vary depending on location and what services are to be provided. Alternatively, base staff can be trained to provide workshops utilizing EDSA Group curricula. Again, fees will vary depending on the nature and amount of training to be provided.

WHERE TO FIND MORE INFORMATION

The EDSA Group, Inc.
One Oak Square
8280 YMCA Plaza Drive, #4
Baton Rouge, LA 70810
TOLL-FREE: (800) 942-2777
Fax: (225) 291-0419
Email: info@theedsagroup.com
URL: www.theedsagroup.com

Self Control Training

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Finances

DESCRIPTION

Whereas the EDSA Group workshops described above primarily target saving and investing, self-control training involves learning to reward oneself for changing a bad habit — in this case, inefficient, impulsive spending.

MINIMAL IMPLEMENTATION

Participants meet in small groups for one hour per week over a 4-week period. Two weeks prior to the first meeting, they are informed that for the next 6 weeks, they will be required to turn in comprehensive weekly spending reports. These reports should be user-friendly forms that include daily totals for money spent on housing, food, transportation, clothing, personal care (e.g., cosmetics, haircuts), medical care, recreation, and an "other" category (e.g., insurance, gifts, charitable donations, savings). The forms should also include space for recording income before taxes, as well as balances on savings and checking accounts and credit cards.

At the first weekly meeting, the participants learn the basic principles that make the intervention work. They are taught that they will be rewarding themselves for behaving in ways that interfere with bad spending habits. Each person then compiles a list of possible rewards (e.g., soda, watching television) and a list of self-defeating financial habits (e.g., excessive use of credit cards, borrowing money from friends, impulsive spending). Finally, each participant chooses one specific habit to work on during the following week (e.g., not going downtown or to the mall without a specific purpose in mind). It is emphasized that they should set realistic goals and not expect extraordinary results immediately. They are instructed to use self-praising thoughts (e.g., "I am so in control") as well as tangible rewards from their list whenever they engage in an activity that competes with unnecessary or impulsive spending.

At the second meeting, each participant's progress is discussed, and the importance of breaking self-defeating chains of behavior as early as possible is emphasized. Further suggestions are made, including destroying credit cards, making and keeping to a budget, and avoiding carrying either credit cards or a checkbook when going anywhere. Participants choose a second self-defeating behavior as the target for the week.

The third meeting again involves a discussion of progress and further suggestions, including carrying only small amounts of money when going out, making shopping lists and sticking to them, taking only enough money to purchase what was on the list, keeping cash at home in labeled envelopes for specific purposes (e.g., clothing, entertainment), not borrowing money unless absolutely necessary, and setting up a

priority list of items or events toward which participants would like to save (e.g., clothes, travel, camera).

At the fourth meeting, everyone reviews and comments on the progress they have made. In addition to practicing the self-control techniques they have already learned, participants are encouraged to open a bank account, with any interest earned spent however they wish. It is also suggested that they try to perform various tasks that they would ordinarily pay someone else to do (e.g., changing the oil in their own car, packing their lunch rather than buying it) and depositing the money saved in this way directly into their bank account.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

This intervention was originally designed and tested over 25 years ago (Paulsen, Rimm, Woodburn, & Rimm, 1977). All participants in the validation study saw themselves as overspenders, and were assigned to attend either a self-control training group as outlined above, or a group that met for four weeks and simply discussed financial problems. Participants in the self-control group reported reducing their discretionary spending, on average, by a whopping *55%* over the course of the 4 weeks, while those who attended the discussion group were spending slightly more than they had before attending. The effects of self-control training were still present 3 months following participation.

RESOURCES REQUIRED

Necessary resources include forms that can be used to track spending, a place in which to meet, and someone to lead and instruct the group.

WHERE TO FIND MORE INFORMATION

N/A

NEFE High School Financial Planning Program

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Finances

DESCRIPTION

The National Endowment for Financial Education (NEFE) is a non-profit foundation whose mission is to help all Americans gain the information and obtain the skills necessary to take control of their personal finances. Focusing many of its efforts on increasing the financial literacy of our nation's youth, NEFE recently developed and evaluated the High School Financial Planning Program (HSFPP), which consists of six basic modules:

- *Financial Planning: Your Roadmap,* an introduction to the financial planning
- process
- *Careers: Labor You Love,* on the relationship between career/work factors and
- earning potential
- *Budget: Don't Go Broke,* about developing a personal spending/savings plan
- *Savings and Investments: Your Money at Work,* on the importance of saving
- and investing and the benefits of using the time value of money
- *Managing Credit: Buy Now, Pay Later,* about using and managing credit
- effectively
- *Insurance: Your Protection,* about how to protect assets by means of
- appropriate insurance

MINIMAL IMPLEMENTATION

The entire HSFPP program can take as little as 10 hours to present. Modules may be presented over the course of anywhere between two or three weeks to several months.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

The HSFPP has been evaluated in a national sample of 4,107 high school students, 94% of whose teachers used at least four modules in their classrooms (Danes, Huddleston-Casas, & Boyce, 1999). On average, participants reported significant improvements in financial knowledge, financial management behaviors, and financial self-confidence following the program. For example, 50% of participants reported knowing more about the cost of buying on credit; 49% knew more about investments. About a third reported gains in setting and meeting financial goals, tracking expenses, and saving. Forty-two percent said they felt more confident in their ability to make decisions involving money. All results were maintained three months after the program ended.

RESOURCES REQUIRED

A room in which to conduct the class is needed, along with someone who has learned to present the modules. All English-language materials for instructors and participants are available free of charge from NEFE (see below); manuals can also be downloaded and

printed in Spanish. NEFE also offers a web-based training program for instructors, as well as online support sites for both instructors and students.

WHERE TO FIND MORE INFORMATION

National Endowment for Financial Education
NEFE High School Financial Planning Program
5299 DTC Blvd., Suite 1300
Greenwood Village, CO 80111
Tel: (303) 224-3511
Fax: (303) 220-0838
Email: eas@nefe.org
URL: www.nefe.org

Personal Finances References

Introduction

American Bankruptcy Institute. (n.d.) *U.S. Bankruptcy Filings 1980-2002.* Retrieved September 1, 2003, from http://www.abiworld.org/stats/1980annual.html.

Braunstein, S., & Welch, C. (2002). Financial literacy: An overview of practice, research, and policy. *Federal Reserve Bulletin, 88,* 445-458.

Employee Benefit Research Institute. (1998). *Summary of findings: 1998 RetirementConfidence Survey.* Retrieved August 26, 2003, from http://www.ebri.org/rcs/1998/RCS.htm.

Garman, E. T., Leech, I. E., & Grable, J. E. (1996). The negative impact of employee poor personal financial behaviors on employers. *Financial Counseling and Planning, 7,* 157-168.

Gorbach, T. R. (1997). A case for comprehensive financial education in the workplace. *Personal Finances and Worker Productivity, 1,* 66-70.

Joo, S., & Grable, J. E. (2000). Improving employee productivity: The role of financial counseling and education. *Journal of Employment Counseling, 37,* 2-15.

Kottler, J. A. (1999). *Exploring and treating acquisitive desire: Living in the material world.* Thousand Oaks, CA: SAGE.

EDSA Group Workshops (Youth)

Danes, S. M., Huddleston-Casas, C. & Boyce, L. (1999). Financial Planning Curriculum For Teens: Impact Evaluation. *Financial Counseling and Planning, 10,* 25-37.

EDSA Group Workshops

Garman, E. T., Kim, J., Kratzer, C. Y., Brunson, B. H., & Joo, S. (1999). Workplace financial education improves personal financial wellness. *Financial Counseling and Planning, 10,* 79-88.

Self-Control Training

Paulsen, K., Rimm, D. C., Woodburn, L. T., & Rimm, S. A. (1977). A self-control approach to inefficient spending. *Journal of Consulting and Clinical Psychology, 45,* 433-435.

NEFE High School Financial Planning Program

Danes, S. M., Huddleston-Casas, C. & Boyce, L. (1999). Financial planning curriculum for teens: Impact evaluation. *Financial Counseling and Planning, 10,* 25-37.

Personal Coping

Introduction

Stress is a part of everyone's life. Stress is unavoidable, as it is our adaptation to changes in our environments. Stress can have positive effects — for example, it can make life more exciting and interesting and force us to be creative problem-solvers. On the other hand, stress can have extremely negative effects on physical and mental well-being — for example, it can lead to tension and anxiety, depression, interpersonal problems, and hypertension (see Machacova, 1999). In addition, stress and the inability to cope with it are risk factors for domestic violence, substance abuse, and suicide (Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001; Sinha, 2001; Yufit & Bongar, 1992).

The interventions listed in this section have all been shown to significantly increase people's perceptions that their lives are going well, that they are able to cope with the stressors they face. The methods vary from direct instruction in coping skills to aerobic exercise, and all of the interventions also influence other NORTH STAR-targeted risk factors.

Items in 2003 AF Community Assessment	Item #s
1. Successfully copes with stress	H1b
2. Maintains positive relationships	H1d, F1
3. Willing to ask for help with a major problem	H1f
4. Satisfied with emotional well-being	H2a
5. Satisfied with life as a whole	H2b
6. Successfully manages family and work demands	M4

Activities/Interventions
Stress and the Healthy Mind
Unstress
NoonTime Walkers
Triple P
Couples Coping Enhancement Training (CCET)
Community Gardens
Cognitive Relaxation Coping Skills (CRCS)

Stress and the Healthy Mind

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Coping ★ Depressive Symptoms ★ Anger/Hostility ★ Anxiety ★ Self-Esteem

DESCRIPTION

Stress and the Healthy Mind (HLTH 486) is a college course that has been taught at the University of Maryland since 1990. As implied by the course title, it was designed to improve overall mental health and decrease the impact of stress on the participants.

During the course, the instructor outlines life characteristics and habits that are likely lead to mental health versus mental illness. Each participant is assigned to come up with, implement, and monitor a sensible sleeping, eating, and exercising plan. Skills to prevent depression and problematic anger, reduce anxiety and worry, and increase self-esteem are taught and practiced in class and at home.

MINIMAL IMPLEMENTATION

At the University of Maryland, the course meets twice weekly, ninety minutes each session, for fifteen weeks. The number of participants in a class is generally limited to fewer than fifteen, so as to promote discussion, skill practice, and teamwork.

This course could be taught on-base as part of AD members' training or offered to the general base community. Bryant (2000) has also suggested that an organization such as the FBI or the military might form mutually beneficial alliances with local colleges, which could offer stress-reduction courses such as this one to the employees and/or families of the organization.

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

Participation in the course has been found to significantly reduce depression, anxiety, and hostility, and to significantly increase the participants' self-esteem (Brown, 2002; Schiraldi & Brown, 2001; 2002). The effects were maintained at least one month after completing the course.

RESOURCES REQUIRED

A course outline and a list of readings and other needed materials are available from the course's developer (see below).

Glenn R. Schiraldi, Ph.D.
2387 HHP Building, Valley Drive
College Park, MD 20742
Tel: (301) 405-2518
Fax: (301) 314-9167
Email: gs6@umail.umd.edu
URL: http://www.dpch.umd.edu/people/faculty/schiraldi_gr.html

Unstress

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Coping ★ Anxiety

DESCRIPTION

In the late 1980s, a team of New Zealand researchers noticed that there were no widely available, relatively low-cost, community-based interventions for stress management (unlike, say, Weight Watchers for weight control). They decided to work with members of their community to create one. The result was "Unstress."

Unstress participants meet in groups to discuss principles and skills related to successfully coping with stress; topics include prioritizing, time management, goal setting, decision making, assertiveness, and relaxation, among others. "Homework" is assigned in each session, and personal progress is reported on the next week.

MINIMAL IMPLEMENTATION

Groups of 6-9 participants hold weekly meetings for 10 weeks; each sessions lasts about 90 minutes. The first Unstress groups in a given area are run by professionals from the organization that is implementing the intervention; successful "graduates" of the intervention are then recruited and trained to lead future groups. (Other than starting discussions and helping to set up groups, group leaders act as participants rather than "experts.")

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

Participation in the Unstress intervention has been shown to significantly reduce tension and anxiety, while increasing the perceived ability to cope and a general sense of well-being (Raeburn, Atkinson, Dubignon, McPherson, & Elkind, 1993). Ninety percent of the participants rated the course positively, and even one year after their groups finished meeting, over 80% reported that overall, having participated in Unstress was still helping them to cope.

RESOURCES REQUIRED

Professional involvement is kept to a minimum, printed materials are bulk photocopied, and the only other necessary resources are blank audiocassette tapes and locations in which the groups can meet; thus, the Unstress intervention is extremely low-cost. In 1993, it was estimated that running a group cost roughly US$12 per participant ($1.20/session), plus US$12 per session to pay the lay group leader. Training materials, handouts, relaxation tapes are available from Dr. John Raeburn (see below).

John Raeburn
Department of Psychiatry and Behavioural Science
School of Medicine
University of Auckland
Private Bag 92019
Auckland 1
NEW ZEALAND
Email: jm.raeburn@auckland.ac.nz

NoonTime Walkers (see page 79)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Physical Activity ★ Personal Coping ★ Anxiety

Triple P (see page 60)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Relationship Satisfaction ★ Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depressive Symptoms (Levels 4 & 5 only) ★ Personal Coping ★ Anxiety (Levels 4 & 5 only)

Couples Coping Enhancement Training (CCET) (see page 39)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Relationship Satisfaction ★ Family Coping	★ Personal Coping

Community Gardens (see page 13)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
★ Community Unity ★ Support from Neighbors			★ Healthy Diet ★ Personal Coping

Cognitive Relaxation Coping Skills (CRCS) (see page 104)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Anger/ Hostility ★ Personal Coping

Coping with Work and Family Stress™ (see page 26)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress		★ Personal Coping ★ Depressive Symptoms ★ Anxiety ★ Alcohol Expectancies

Personal Coping References

Introduction

Machacova, H. (1999). *Behavioural prevention of stress.* Prague, Czech Republic: Charles University.

Schumacher, J. A., Feldbau-Kohn, S., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behavior, 6,* 281-352.

Sinha, R. (2001). How does stress increase risk of drug abuse and relapse? *Psychopharmacology, 158,* 343-359.

Yufit, R. I., & Bongar, B. (1992). Suicide, stress, and coping with life cycle events. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 553-573). New York: Guilford.

Stress and the Healthy Mind

Brown, S. L. (2002). Teaching preventive mental health skills to functional college students: A comparison of three classroom-based interventions. *Dissertation Abstracts International, 62*(9), 3966B.

Bryant, H. E. (2000). Stress factors and stress management strategies for FBI agent spouses: Basis for potential community college workshops and classes. *Dissertation Abstracts International, 60*(7), 2692A.

Schiraldi, G. R., & Brown, S. L. (2001). Primary prevention for mental health: Results of an exploratory cognitive-behavioral college course. *Journal of Primary Prevention, 22,* 55-67.

Schiraldi, G. R., & Brown, S. L. (2002). Preventive mental health education for functioning adults: Stress, coping and mental health courses at the University of Maryland. *International Journal of Emergency Mental Health, 4*, 57-64.

Unstress

Raeburn, J. M., Atkinson, J. M., Dubignon, J. M., Mcpherson, M., & Elkind, G. S. (1993). "Unstress": A low-cost community psychology approach to stress-management: An evaluated case study from New Zealand. *Journal of Community Psychology, 21,* 113-123.

Anger

Introduction

Almost everyone gets angry now and then; anger is a natural emotional response to frustrating situations. However, excessive or uncontrolled anger can have a negative impact on enjoyment of life, personal relationships, and physical health (Del Vecchio and O'Leary, in press). It can lead to problems in the workplace (Glomb, 2002) and/or dangerous driving behaviors (Deffenbacher, Huff, Lynch, Oetting, and Salvatore, 2000.

Over the past 25 years, several effective techniques for managing anger have been developed. The interventions listed in this section have all been shown to either improve people's perception that their anger is under control or to decrease aggressive behavior and increase prosocial behavior. Attitudes toward violence and aggression are also addressed in this section in the form of a intervention that teaches people not to think of aggression as a way to handle problems.

Activities/Interventions
Cognitive-Relaxation Coping Skills (CRCS)
RETHINK
Stress and the Healthy Mind
Changing the Sexual Aggression-Supportive Attitudes of Men

Cognitive Relaxation Coping Skills (CRCS)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Anger/ Hostility ★ Personal Coping

DESCRIPTION

Cognitive Relaxation Coping Skills (CRCS) is a combination of two common methods used for helping people manage their anger: cognitive coping skills and relaxation training (Deffenbacher & Stark, 1992). During the first two sessions, a rationale for the intervention is introduced and participants are trained in various relaxation techniques. In Session 3, the group focuses on changing thoughts that lead to and maintain anger. Sessions 4-8 involve the application of cognitive and relaxation coping strategies to a variety of anger-inducing situations. Homework is assigned each week and involves practicing the skills that were taught in each session.

MINIMAL IMPLEMENTATION

Groups of 9-11 participants hold weekly meetings for 8 weeks; each sessions lasts about 60 minutes. The groups are run by professionals who follow a published treatment manual (Deffenbacher & McKay, 2000b).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

CRCS has been used extensively with college students who identify themselves as having "high anger," and has also been shown to be effective for angry drivers (Deffenbacher, Huff, Lynch, Oetting, & Salvatore, 2000) and for adolescents with high levels of anger (Deffenbacher, Lynch, Oetting & Kemper, 1996). In a series of excellent studies, Deffenbacher and his colleagues have demonstrated that CRCS can effectively reduce participants' anger both in the short term and 12 to 15 months following intervention participation (Deffenbacher, 1988; Deffenbacher, Oetting, Huff, & Thwaites, 1995; Deffenbacher, Thwaites, Wallace, & Oetting, 1994).

RESOURCES REQUIRED

Professional facilitation of the meetings is required. A training manual for facilitators and a user's manual for participants are available (Deffenbacher & McKay, 2000a; 2000b). The only other resource needed is a location in which the groups can meet. .

WHERE TO FIND MORE INFORMATION

Jerry L. Deffenbacher, Ph.D.
Psychology Department
Colorado State University
Fort Collins, CO 80523
Tel: (970) 491-6871
Email: jld6871@lamar.colostate.edu
URL: http://psy.psych.colostate.edu/psylist/detail.asp?Num=14

Changing the Sexual Aggression-Supportive Attitudes of Men: A Psychoeducational Intervention

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Approval of Aggression

DESCRIPTION

This one-hour presentation consists of arguments in favor of rejecting interpersonal violence, rape myths, adversarial sexual beliefs, and male dominance. Participants watch the presenters role-play vignettes. Presenters then discuss the negative consequences of accepting interpersonal violence, rape myths, adversarial sexual beliefs, and male-dominance ideology. They also discuss the social consequences of accepting these beliefs. After the presentation, participants are encouraged to discuss their thoughts with the presenters.

MINIMAL IMPLEMENTATION

This presentation requires two people who are trained in role-playing vignettes and facilitating discussion. The presentation takes about 1 hour and can be given to a large group.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Attitudes toward interpersonal violence, adversarial sexual beliefs, acceptance of rape myths, and sex role stereotyping were measured just prior to and after the presentation. Compared to those of nonparticipants, attitudes of participants changed significantly. A one-month follow-up indicated that participants in the presentation were more willing to listen to a telephone solicitor who was seeking volunteers for a women's safety project (Gilbert, Heesacker, & Gannon, 1991). The researchers interpreted this to mean that the self-reported attitude changes had generalized to a more naturalistic situation. No attempts to replicate this study have been reported in the literature; however, similar presentations have also been found to be effective in altering men's attitudes towards violence toward women (O'Neal & Dorn, 1998).

RESOURCES REQUIRED

Copies of a sample transcript of the presentation, as well as other materials, can be obtained from Dr. Martin Heesacker (see below). The only other resource required is a room in which the presentation can be offered.

Martin Heesacker, Ph.D.
Department of Psychology
P. O. Box 112250
Gainesville, Florida 32611-2250
Tel: (352) 392-0601 ext 200
Fax: (352) 392-7985
Email: heesack@ufl.edu
URL: www.psych.ufl.edu/~heesacker/

Stress and the Healthy Mind (see page 96)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Coping ★ Depressive Symptoms ★ Anger/Hostility ★ Anxiety ★ Self-Esteem

RETHINK (see page 71)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parents' Sense of Competence ★ Inappropriate Expectations for Children's Behavior ★ Use of Corporal Punishment	★ Anger/ Hostility

Anger References

Introduction

Deffenbacher, J. L., Huff, M. E., Lynch, R. S., Oetting, E. R., & Salvatore, N. F. (2000). Characteristics and treatment of high-anger drivers. *Journal of Counseling Psychology, 47*, 5-17.

Del Vecchio, T., & O'Leary, K. D. (in press). Effectiveness of anger treatments for specific anger problems: A meta-analytic review. *Clinical Psychology Review.*

Glomb, T. M. (2002). Workplace anger and aggression: Informing conceptual models with data from specific encounters. *Journal of Occupational Health Psychology, 7*, 20-36 .

Cognitive Relaxation Coping Skills (CRCS)

Deffenbacher, J. L. (1988). Cognitive-relaxation and social skills treatments of anger: A year later. *Journal of Counseling Psychology, 35*, 234-236.

Deffenbacher, J. L., Huff, M. E., Lynch, R. S., Oetting, E. R., & Salvatore, N. F. (2000). Characteristics and treatment of high-anger drivers. *Journal of Counseling Psychology, 47*, 5-17.

Deffenbacher, J. L., Lynch, R. S., Oetting, E. R., & Kemper, C. C. (1996). Anger reduction in early adolescents. *Journal of Counseling Psychology, 43*, 149-157.

Deffenbacher, J. L., and McKay, M (2000a). *Overcoming situational and general anger.* Oakland, CA: New Harbinger.

Deffenbacher, J. L., and McKay, M (2000b). *Overcoming situational and general anger: A protocol for the treatment of anger based on relaxation, cognitive restructuring, and coping skills training.* Oakland, CA: New Harbinger.

Deffenbacher, J. L, Oetting, E. R., Huff, M. E., & Thwaites, G. A. (1995). Fifteen-month follow-up of social skills and cognitive-relaxation approaches to general anger reduction. *Journal of Counseling Psychology, 42*, 400-405.

Deffenbacher, J. L., & Stark, R. S. (1992). Relaxation and cognitive-relaxation treatments of general anger. *Journal of Counseling Psychology, 39*, 158-167.

Deffenbacher, J. L., Thwaites, G. A., Wallace, T. L., & Oetting, E.R. (1994). Social skills and cognitive-relaxation approaches to general anger reduction. *Journal of Counseling Psychology, 41*, 386-396.

Changing the Sexual Aggression-Supportive Attitudes of Men: A Psychoeducational Intervention

Gilbert, B.J., Heesacker, M., & Gannon, L.J. (1991). Changing the sexual aggression-supportive attitudes of men: A psychoeducational intervention. *Journal of Counseling Psychology, 38*, 197-203.

O'Neal, M. F., &Dorn, P.W. (1998). Effects of time and an educational presentation on student attitudes toward wife-beating. *Violence and Victims, 13*, 149-157.

Depressive Symptoms

Introduction

Depression is a debilitating and relatively common problem. The World Health Organization has identified major depression as the fourth leading cause of disability worldwide, and projects that it will be the second leading cause by 2020 (Murray & Lopez, 1996). In the U.S. it is estimated that over 17% of all people in the U.S. will suffer from clinical depression at some point during their lives (Kessler et al., 1994), and that at any given point in time, roughly 5% of the adult population is clinically depressed (Blazer, Kessler, McGonagle, & Swartz, 1994). Subclinical levels of depressive symptoms are even more common, as well as predictive of increased mortality and a fourfold risk increase for a major depressive episode (Cuijpers & Smit, 2002; Horwath, Johnson, Lerman, & Weissman, 1994).

Treatment for depression typically takes place either via one-on-one professional contact (i.e., individual psychotherapy and/or prescription of antidepressant medication) or via group therapy. However, in a given year, only about one in five individuals who have a psychiatric disorder like depression will seek professional help (Kessler et al., 1994), and subclinical depression often goes unrecognized — by both the depressed individual and the health care system — and therefore untreated.

The interventions listed in this section have been shown to significantly reduce depressive symptoms. One, *Feeling Good*, targets depression specifically and exclusively. The other interventions also address other risk factors targeted by NORTH STAR, such as Parent-Child Relationships and/or Perceived Personal Coping.

Items in 2003 AF Community Assessment	Item #s
1. Can't get going	H5a
2. Sad	H5b
3. Can't sleep	H5c
4. Everything feels like an effort	H5d
5. Lonely	H5e
6. Can't shake the blues	H5f
7. Can't concentrate	H5g

Activities/Interventions
Feeling Good
Family Thriving Program
Triple P (Levels 4 & 5 only)
Stress and the Healthy Mind

Feeling Good

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Depressive Symptoms

DESCRIPTION

Negative thoughts and beliefs (e.g., "I'm worthless," "It's all hopeless," "I can't ever do anything right," "I hate myself") can often lead to and/or accompany depressive symptoms. Dr. David Burns wrote *Feeling Good*, a self-help classic originally published in 1980, to enable readers to combat these thoughts and thereby reduce their depression.

Written at about a 6th-grade reading level (Scogin, Jamison, & Gochneaur, 1989), the book has recently been revised and updated (Burns, 1998). This latest version is 706 pages long, available in paperback, and relatively inexpensive. It contains a self-administered test so that readers can gauge how depressed they are. Most chapters also contain exercises for readers to complete; these exercises are similar to those that would be assigned by a cognitive psychotherapist.

MINIMAL IMPLEMENTATION

A main advantage of the *Feeling Good* intervention is that it is self-administered. Of course, in order for individuals to be considered "treated," they must read at least some of the book. As a general guideline, participants in the Jamison & Scogin (1995) study reported having read between 23% and 100% of the book (average 83%). If desired, a quiz is available that reliably distinguishes between those who have read the book and those who have not (Scogin, Jamison, Floyd, & Chaplin, 1998). It may be critical to inform intervention participants in advance that they will receive a book to read, not traditional psychotherapy (Scogin, Floyd, Jamison, Ackerson, Landreville, & Bissonnette, 1996).

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Mildly-to-moderately-depressed adults who read *Feeling Good* over a 1-month period reported decreases in depressive symptoms, frequency of negative thoughts, and dysfunctional attitudes (Jamison & Scogin, 1995). Seventy percent of those who read the book no longer met criteria for major depression, while only 3% of controls were no longer clinically depressed. Later, after they had also read the book, 73% of controls did not meet clinical depression criteria. Treatment gains were maintained at 3-year follow-up (Smith, Floyd, Scogin, & Jamison, 1997).

RESOURCES REQUIRED

One copy of *Feeling Good* is required per individual/family to be treated. (Purchases of 50 books or more receive a discount of 40-45% from the publisher.) In the validation studies, participants received weekly phone calls for assessment purposes and to answer any questions (e.g., "What does the book mean when it says. . .?", "How many pages am I supposed to read this week?"). We recommend that the phone number and email address of a intervention contact person (e.g., someone from Life Skills) be provided

inside the front cover of the book. The contact person should be someone who is familiar with the book and its concepts and could answer questions. In addition, calling individuals/families who have received the book to see how their reading is progressing and answer any questions may be a good way to increase the reading rate.

WHERE TO FIND MORE INFORMATION

For information about bulk purchases, contact:

Special Markets Department
HarperCollins Publishers, Inc.
10 East 53rd Street
New York, NY 10022-5299
Tel: (212) 207-7528
Fax: (212) 207-7222

MoodGYM

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Depressive Symptoms ★ Anxiety

DESCRIPTION

MoodGYM is a free Internet-based cognitive behavior therapy (CBT) intervention designed to treat and prevent symptoms of depression. It is available to all Internet users and is particularly targeted to those who have no formal contact with formal mental health services.

The MoodGYM website consists of 5 CBT modules, a personal workbook containing 29 activities and assessments (each user's responses are recorded and updated individually), an interactive game, and a feedback form (Christensen, Griffiths, & Korten, 2002). Though it is not the easiest site to navigate, MoodGYM is very thorough and sophisticated in its CBT content. Topics covered include:

- How mood is influenced by thinking
- How to recognize and overcome dysfunctional thoughts
- Assertiveness
- Self-esteem training
- Relaxation training
- Problem solving

NOTE: MoodGYM also contains resource guides referring or linking site users who click on them to external depression resources. As it is based in Australia, the main site lists primarily Australian resources. However, the site administrators have indicated that for a small fee, they can customize the resource guides for users logging in from NORTH STAR bases.

MINIMAL IMPLEMENTATION

Since it is Internet-based, MoodGYM is entirely self-administered. Therefore, each participant determines how much of the intervention they will implement, as well as how quickly they will progress through the modules (each of which was designed to take 30 to 45 minutes to complete). While earlier versions of the website allowed users to move about the site at will, the current version (Mark II) requires all users to complete the modules and assessments in optimal sequence.

DOCUMENTED RESULTS (Empirical Evidence: **Best**)

Despite its relatively recent development, MoodGYM has already been well evaluated, with further investigations ongoing. In a large-scale randomized controlled trial (Christensen, Griffiths, & Jorm, 2004), MoodGYM participants' symptoms of depression and anxiety decreased significantly more than control participants' symptoms; this was in spite of the fact that on average MoodGYM participants only completed about half of the

program. Other studies have shown that MoodGYM's impact increases with (a) higher (i.e., worse) initial depression scores, (b) longer exposure to the site, and (c) completion of more of the site material (Christensen, Griffiths, Groves, & Korten, 2006; Christensen, Griffiths, & Korten, 2002). Furthermore, self-referred site users improved just as much as controlled trial participants, even though the latter received weekly telephone calls to guide their progress through the modules and assessments (Christensen, Griffiths, Korten, Brittliffe, & Groves, 2004). Data regarding possible long-term effects of MoodGYM participation on depression and/or anxiety have not yet been reported.

RESOURCES REQUIRED

Use of the website is free. All prospective participants need is access to the Internet. Otherwise, implementation will require only a creative plan for marketing it to as many members of the base community as possible, resources to carry out the plan, and a system to track implementation. Additional resources may also be required when evaluating the impact of this activity (see the online NORTH STAR Evaluation Guide).

WHERE TO FIND MORE INFORMATION

Helen Christensen
Deputy Director
Centre for Mental Health Research
Australian National University
Email: helen.christensen@anu.edu.au
URL: http://moodgym.anu.edu.au/

BluePages

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Depressive Symptoms

DESCRIPTION

BluePages is a free Internet-based activity designed to provide evidence-based information (at an 8th-grade reading level) on depression and its treatment. It is available to all Internet users and is particularly targeted to those who have no formal contact with mental health services.

The BluePages website is easily navigated and consists entirely of psychoeducational information on depression. It is not designed as a treatment per se. Topics covered include:

- The symptoms of depression and how it is diagnosed
- Which medical, psychological, and alternative treatments work for depression (and which don't)
- Resources (people, books, organizations, websites, etc.)

The site also includes screening measures of depression and anxiety (so that users can gauge how depressed or anxious they are compared to same-age peers), as well as links to external resources, including BluePages' sister site, the intervention-minded MoodGYM (see page 112). Although the website is based in Australia, BluePages' resource guides also contain links to U.S. resources.

MINIMAL IMPLEMENTATION

Since it is Internet-based, BluePages is entirely self-administered. Therefore, each participant determines how much of the intervention they will implement, as well as how quickly they will do so.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

In a large-scale randomized controlled trial (Christensen, Griffiths, & Jorm, 2004), BluePages participants received six scripted, weekly telephone calls reminding and assigning them to visit specific sections of the site. Only 15% of participants assigned to the BluePages group dropped out. On average, participants logged into the website between 4 and 5 times; after six weeks, site visitors' depressive symptoms decreased significantly more than control participants' symptoms. Long-term effectiveness of BluePages use in treating or preventing depression has not yet been investigated; it has also not been reported whether the site has an effect in the absence of weekly reminder calls.

RESOURCES REQUIRED

Use of the website is free. All prospective participants need is access to the Internet. Otherwise, implementation will require only a creative plan for marketing it to as many members of the base community as possible, resources to carry out the plan, and a system

to track implementation. Resources may also be required when evaluating the impact of this activity (see the online NORTH STAR Evaluation Guide).

WHERE TO FIND MORE INFORMATION

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FeelBetter

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Depressive Symptoms

DESCRIPTION

Sponsored by the Kaiser Permanente Center for Health Research, FeelBetter is a free, Internet-based cognitive therapy intervention designed to treat and prevent symptoms of depression. It was developed from some of the materials contained in a popular self-help book for depression (Lewinsohn, Munoz, Youngren, & Zeiss, 1986) and is available to all Internet users.

The FeelBetter website consists of 8 different chapters, or "sessions." Each given chapter may contain educational information, illustrative cartoons, and/or interactive exercises designed to help site visitors recognize and overcome depressive patterns of thinking. Topics covered include:

- What depression is and how it is caused
- Recognizing and challenging dysfunctional thoughts
- Creating positive "counterthoughts"

FeelBetter is written at about an 8th-grade reading level, and it is relatively easy to navigate. However, as presently constituted, the site focuses entirely on cognitive aspects of depression. It does not address behavioral skills, such as increasing rewarding activity, problem-solving, and assertiveness, that are commonly targeted when treating depressed individuals.

MINIMAL IMPLEMENTATION

Since it is Internet-based, FeelBetter is entirely self-administered. Therefore, each participant determines how much of the intervention they will implement, as well as how quickly they will progress through the chapters (each of which was designed to take only 5 or 10 minutes to complete).

DOCUMENTED RESULTS (Empirical Evidence: **Good**)

To date, FeelBetter has been evaluated in two randomized controlled trials (Clarke, Eubanks, et al., 2005; Clarke, Reid, et al., 2002). In one study, participants in the intervention condition received regular postcard or telephone reminders encouraging them to access the website; in the other, no such reminders were provided. Without reminders, program participants accessed the website two or three times on average; no overall effect of intervention participation was found, though post hoc analyses revealed a modest (d = .18) improvement, compared to controls, among participants who reported relatively low levels of initial depression. With reminders, however, program participants accessed the website an average of six times; the "reminder" groups experienced significantly greater (d = .28) reductions in depressive symptoms at 16-week follow-up than did treatment-as-usual controls, with an even more pronounced effect (d = .54) found among participants who

were more severely depressed at baseline. Data regarding possible long-term effects of FeelBetter participation on depression have not yet been reported.

NOTE: Based on the research findings discussed above, it is strongly recommended, if this intervention is selected for implementation, that some sort of reminder system be included in your implementation plan. This may be difficult if you are simultaneously attempting to preserve participant anonymity.

RESOURCES REQUIRED

Use of the website is free. All prospective participants need is access to the Internet. Otherwise, implementation will require only a creative plan for marketing it to as many members of the base community as possible, resources to carry out the plan, and a system to track implementation. Resources may also be required when evaluating the impact of this activity (see the online NORTH STAR Evaluation Guide).

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Family Thriving Program (see page 58)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Parent-Child Relationships	★ Depressive Symptoms

Triple P (Ages birth-12) (see page 60)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
		★ Child Externalizing Behavior Problems (Levels 1-5) ★ Parents' Sense of Competence (Levels 1-5) ★ Parent-Child Relationships (Levels 1-5) ★ Relationship Satisfaction ★ Family Coping ★ Child Internalizing Behavior Problems (Levels 4 & 5 only)	★ Depressive Symptoms (Levels 4 & 5 only) ★ Personal Coping ★ Anxiety (Levels 4 & 5 only)

Stress and the Healthy Mind (see page 96)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Personal Coping ★ Depressive Symptoms ★ Anger/Hostility ★ Anxiety ★ Self-Esteem

Coping with Work and Family Stress™ (see page 26)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress		★ Personal Coping ★ Depressive Symptoms ★ Anxiety ★ Alcohol Expectancies

Depressive Symptoms References

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Thoughts and Beliefs about Alcohol and Drugs

Introduction

People vary widely in what they think and believe about the use and effects of alcohol and other drugs. Many of these substance-related thoughts and beliefs are related to people's substance use and abuse patterns, and have been effectively targeted by prevention activities. Examples relevant to NORTH STAR are included here.

"Alcohol expectancies" are the outcomes — positive or negative — that are expected to result from the consumption of alcohol. These expectancies are strongly related to the amount of alcohol people choose to consume and their risk for alcohol abuse (Jones, Corbin, & Fromme, 2001; Kilbey, Downey, & Breslau, 1998). For example, those who expect that having a few drinks will make them "the life of the party" or improve their sexual performance tend to consume more alcohol. On the other hand, those who expect that drinking — or drinking too much — will lead to a hangover, impair their sexual performance, or make them appear stupid tend to restrain their drinking behavior.

In the workplace, in addition to having inaccurate beliefs regarding drug and alcohol usage among their peers, civilians may also lack knowledge regarding their organization's drug and alcohol policies and Employee Assistance Program (EAP). This may lead them to distrust EAP confidentiality and/or to stigmatize help-seeking (Beidel, 1999). (Similar issues may affect the Air Force's Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program.) Trust/confidentiality issues are thought to be the main reasons why workers often fail to seek help for drug or alcohol problems in themselves or their colleagues.

The interventions described below have been designed to beneficially affect people's thoughts and beliefs about substance use, and thereby to reduce substance consumption.

Activities/Interventions
Alcohol Expectancy Challenge
Team Awareness

Alcohol Expectancy Challenge

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
			★ Alcohol Expectancies

DESCRIPTION

The Alcohol Expectancy Challenge is a brief, inexpensive procedure designed to reduce the expectation that consuming alcohol has noticeable positive effects.

Challenge participants attend sessions in which they consume either (a) an alcoholic beverage or (b) a placebo (e.g., a glass of tonic with a drop of vodka rubbed across the glass rim to make the drink smell and taste of alcohol despite containing none). After participating in group activities, they are asked to use behavioral cues to identify those individuals in the group — including themselves — who had or had not consumed alcohol. The identification errors that are made are used to challenge alcohol expectancies. Between sessions, participants are asked to monitor the alcohol expectancies that are communicated to them (e.g., peers, media); these observations are discussed in the sessions.

MINIMAL IMPLEMENTATION

Groups of 10 to 15 participants meet three times, each session lasting for 1 ½-2 hours. If meeting in mixed-gender groups, the activities in both of the first two sessions consist of party games (e.g., Win, Lose, or Draw). If a group is composed entirely of same-gender participants, during the second session, the group views slides of opposite-gender individuals taken from magazines and advertisements and debates the attractiveness of these individuals. The third session consists of a presentation by a group leader and a wrap-up discussion of alcohol expectancies.

The intervention can be conducted such that in the first two sessions, either half of those who are of legal drinking age receive alcohol and the rest the placebo, or everyone receives the placebo. If all receive the placebo, the actual results of the identification task are not discussed until the second session.

DOCUMENTED RESULTS (Empirical Evidence: **Better**)

Studies have shown that this procedure can significantly reduce positive alcohol expectancies in both men and women, although the changes are greater for men and do not appear to last as long for women (Darkes & Goldman, 1993; 1998; Dunn, Lau, & Cruz, 2000; Musher-Eizenman & Kulick, 2003). Although all participants reported experiencing very little pressure to change their drinking habits, men who were relatively heavy drinkers before participating reduced their consumption of alcohol by about 40% by six weeks after participation. There is no evidence that women's drinking patterns are affected by intervention participation.

RESOURCES REQUIRED

The activity requires collins mix, lemons, glasses, vodka, and flat tonic. Specific instructions and training on how to conduct the intervention are available from the intervention's developer (see below).

WHERE TO FIND MORE INFORMATION

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Team Awareness (see page 31)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Knowledge of Drug and Alcohol Policy ★ Trust in EAP ★ Work Group Cohesiveness		

Coping with Work and Family Stress™ (see page 26)

Intervention Targets			
COMMUNITY	ORGANIZATION	FAMILY	INDIVIDUAL
	★ Job Stress		★ Personal Coping ★ Depressive Symptoms ★ Anxiety ★ Alcohol Expectancies

Thoughts and Beliefs about Alcohol and Drugs References

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Chart 1.

Empirical Evidence Rating Chart

Rating	Activity/ Interventions	Page # (s)
Best	Team Awareness	31, 125
	Premarital Relationship Enhancement Program (PREP)	35
	Triple P (Ages birth-12)	41, 54, 60, 100, 118
	Family Thriving Program (Ages birth-1)	58, 118
	Incredible Years BASIC (Ages 3-8)	65
	Parents Who Care - Guiding Good Choices (ages 9-14)	67
	5 A Day	81
	Cognitive Relaxation Coping Skills (CRCS)	101, 104
	Feeling Good	110
	Coping with Work and Family Stress™	26, 101, 119, 125
	MoodGYM	112
Better	Community Gardens	13, 83, 101
	Personal Stereo Use	21
	Relationship Enhancement (RE)	37
	Couples Coping Enhancement Training (CCET)	39, 54, 100
	Incredible Years ADVANCE (Ages 3-8)	52
	Common Sense Parenting® (Ages 2-17)	63
	Parenting Wisely (Ages 8-18)	69
	Point-of-Decision Prompts	78
	Self-Control Training	90
	Changing the Sexual Aggression-Supportive Attitudes of Men	105
	Alcohol Expectancy Challenge	124
	1-2-3 Magic	50, 57
	Couple CARE	42
	Parenting Newsletters	73
	NEFE High School Financial Planning Program	92
	BluePages	114
Good	Neighborhood Watch/Working it Out	15
	Improved Street Lighting	17
	Stress. . .at Work	23
	RETHINK	71, 107
	NoonTime Walkers	79, 100
	EDSA Group® Workshops	86, 88
	Stress and the Healthy Mind	96, 107, 119
	Unstress	98
	RELATE	44
	FeelBetter	116

Community	Relationship Satisfaction	Family Coping	Parent-Child Relationships	Physical Health	Personal Finances	Personal Coping	Anger	Depression	Thoughts and Beliefs about Alcohol and Drugs	Organizational Factors	Work Group Cohesiveness	Rating
									★		★	Best
	★											
	★	★	★			★		★				
			★					★				
			★									
			★									
				★								
						★	★					
								★				
						★		★	★			
								★				
★				★		★						Better
										★		
	★											
	★	★				★						
		★										
			★									
			★									
				★								
					★							
							★					
									★			
		★	★									
	★											
			★									
					★							
								★				
★												Good
★												
										★		
			★				★			★		
				★		★						
					★							
						★	★	★				
						★						
	★											
								★				

Chart 2.

Risk Factor(s) Addressed

Activity/ Interventions

		Community				Organizational Factors			
	Page	Community Safety	Community Satisfaction	Community Unity	Support from Neighbors	Work Group Cohesiveness	Satisfaction with Employing Organization	Trust in EAP	Job Stress
COMMUNITY									
Community Gardens	13			★	★				
Neighborhood Watch/Working it Out	15	★	★	★					
Improved Street Lighting	17	★							
ORGANIZATIONAL FACTORS									
Personal Stereo Use	21						★		★
Stress. . .at Work	23								★
Coping with Work and Family Stress™	26								★
WORK GROUP COHESIVENESS									
Team Awareness	31					★		★	
RELATIONSHIP SATISFACTION									
Premarital Relationship Enhancement Program (PREP)	35								
Relationship Enhancement (RE)	37								
Couples Coping Enhancement Training (CCET)	39								
Triple P	41								
Couple CARE	42								
RELATE	44								
FAMILY COPING									
1-2-3 Magic (Ages 2-12)	50								
Incredible Years ADVANCE (Ages 3-8)	52								
Triple P	54								
Couples Coping Enhancement Training (CCET)	54								
PARENT-CHILD RELATIONSHIPS									
1-2-3 Magic (Ages 2-12)	57								
Family Thriving Program (birth-1)	58								
Triple P (Ages birth-12)	60								
Common Sense Parenting® (Ages 2-17)	63								
Incredible Years BASIC (Ages 3-8)	65								
Parents Who Care - Guiding Good Choices (ages 9-14)	67								
Parenting Wisely (Ages 8-18)	69								
RETHINK	71								
Parenting Newsletters	73								

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page	Community				Organizational Factors			
		Community Safety	Community Satisfaction	Community Unity	Support from Neighbors	Work Group Cohesiveness	Satisfaction w/ Employing Organization	Trust in EAP	Job Stress
PHYSICAL HEALTH									
Point-of-Decision Prompts	78								
NoonTime Walkers	79								
5 a Day	81								
Community Gardens	83			★	★				
PERSONAL FINANCES									
EDSA Group® Workshops (Youth)	86								
EDSA Group® Workshops	88								
Self-Control Training	90								
NEFE High School Financial Planning Program	92								
PERSONAL COPING									
Stress and the Healthy Mind	96								
Unstress	98								
NoonTime Walkers	100								
Triple P	100								
Couples Coping Enhancement Training (CCET)	100								
Community Gardens	101			★	★				
Cognitive Relaxation Coping Skills (CRCS)	101								
Coping with Work and Family Stress™	101								★
ANGER									
Cognitive Relaxation Coping Skills (CRCS)	104								
Changing the Sexual Aggression-Supportive Attitudes of Men	105								
Stress and the Healthy Mind	107								
RETHINK	107								
DEPRESSIVE SYMPTOMS									
Feeling Good	110								
MoodGYM	112								
BluePages	114								
FelelBetter	116								
Family Thriving Program	118								
Triple P	118								
Stress and the Healthy Mind	119								
Coping with Work and Family Stress™	119								
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS									
Alcohol Expectancy Challenge	124								
Team Awareness	125					★		★	
Coping with Work and Family Stress™	125								

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page	Family										
		Relationship Satisfaction	Parents' Sense of Competence	Parent-Child Relationships	Family Coping	Child Externalizing Behavior	Child Internalizing Behavior	Inappropriate Expectations for Children's Behavior	Special Needs of Child(ren)	Total Child Abuse Potential	Total Child Behavior Problems	Use of Corporal Punishment
COMMUNITY												
Community Gardens	13											
Neighborhood Watch/Working it Out	15											
Improved Street Lighting	17											
ORGANIZATIONAL FACTORS												
Personal Stereo Use	21											
Stress. . .at Work	23											
Coping with Work and Family Stress™	26											
WORK GROUP COHESIVENESS												
Team Awareness	31											
RELATIONSHIP SATISFACTION												
Premarital Relationship Enhancement Program (PREP)	35	★										
Relationship Enhancement (RE)	37	★										
Couples Coping Enhancement Training (CCET)	39	★			★							
Triple P	41	★	★	★	★	★	★					
Couple CARE	42	★										
RELATE	44	★										
FAMILY COPING												
1-2-3 Magic (Ages 2-12)	50			★	★	★						
Incredible Years ADVANCE (Ages 3-8)	52				★							
Triple P	54	★	★	★	★	★	★					
Couples Coping Enhancement Training	54	★			★							
PARENT-CHILD RELATIONSHIPS												
1-2-3 Magic (Ages 2-12)	57						★					
Family Thriving Program (Ages birth-1)	58			★					★			
Triple P (Ages birth-12)	60	★	★	★	★	★	★					
Common Sense Parenting® (Ages 2-17)	63		★	★		★				★	★	
Incredible Years BASIC (Ages 3-8)	65			★		★					★	★
Parents Who Care - Guiding Good Choices (ages 9-14)	67			★		★						
Parenting Wisely (Ages 8-18)	69			★		★						
RETHINK	71		★					★				★
Parenting Newsletters	73			★								

Risk Factor(s) Addressed

Activity/ Interventions

(continued)

Activity/ Interventions	Page	Family										
		Relationship Satisfaction	Parents' Sense of Competence	Parent-Child Relationships	Family Coping	Child Externalizing Behavior	Child Internalizing Behavior	Inappropriate Expectations for Children's Behavior	Special Needs of Children)	Total Child Abuse Potential	Total Child Behavior Problems	Use of Corporal Punishment
PHYSICAL HEALTH												
Point-of-Decision Prompts	78											
NoonTime Walkers	79											
5 A Day	81											
Community Gardens	83											
PERSONAL FINANCES												
EDSA Group® Workshops (Youth)	86											
EDSA Group® Workshops	88											
Self-Control Training	90											
NEFE High School Financial Planning Program	92											
PERSONAL COPING												
Stress and the Healthy Mind	96											
Unstress	98											
NoonTime Walkers	100											
Triple P	100	★	★	★	★	★	★					
Couples Coping Enhancement Training	100	★			★							
Community Gardens	101											
Cognitive Relaxation Coping Skills (CRCS)	101											
Coping with Work and Family Stress™	101											
ANGER												
Cognitive Relaxation Coping Skills (CRCS)	104											
Changing the Sexual Aggression-Supportive Attitudes of Men	105											
Stress and the Healthy Mind	107											
RETHINK	107		★					★				★
DEPRESSIVE SYMPTOMS												
Feeling Good	110											
ModdGYM	112											
BluePages	114											
FeelBetter	116											
Family Thriving Program	118	★			★							
Triple P	118	★	★	★	★	★	★					
Stress and the Healthy Mind	119											
Coping with Work and Family Stress™	119											
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS												
Alcohol Expectancy Challenge	124											
Team Awareness	125											
Coping with Work and Family Stress™	125											

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page	Individual												
		Anger/Hostility	Anxiety	Depressive Symptoms	Personal Finances	Personal Coping	Self Esteem	Approval of Aggression	Alcohol Expectancies	Perceived Alcohol-Related Social Norms	Knowledge of Drug and Alcohol Policy	Physical Health	Healthy Diet
COMMUNITY													
Community Gardens	13					★							★
Neighborhood Watch/Working it Out	15												
Improved Street Lighting	17												
ORGANIZATIONAL FACTORS													
Personal Stereo Use	21												
Stress. . .at Work	23												
Coping with Work and Family Stress™	26		★	★		★			★				
WORK GROUP COHESIVENESS													
Team Awareness	31										★		
RELATIONSHIP SATISFACITON													
Premarital Relationship Enhancement Program (PREP)	35												
Relationship Enhancement (RE)	37												
Couples Coping Enhancement Training (CCET)	39					★							
Triple P	41		★			★							
Couple CARE	42												
RELATE	44												
FAMILY COPING													
1-2-3 Magic (Ages 2-12)	50												
Incredible Years ADVANCE (Ages 3-8)	52												
Couples Coping Enhancement Training	54					★							
Triple P	54		★			★							
PARENT-CHILD RELATIONSHIPS													
1-2-3 Magic (Ages 2-12)	57												
Family Thriving Program (Ages birth-1)	58			★									
Triple P (Ages birth-12)	60		★	★		★							
Common Sense Parenting® (Ages 2-17)	63												
Incredible Years BASIC (Ages 3-8)	65												
Parents Who Care - Guiding Good Choices (ages 9-14)	67												
Parenting Wisely (Ages 8-18)	69												
RETHINK	71	★											
Parenting Newsletters	73												

Risk Factor(s) Addressed Activity/ Interventions (continued)	Page	Individual											
		Anger/ Hostility	Anxiety	Depressive Symptoms	Personal Finances	Personal Coping	Self-Esteem	Approval of Aggression	Alcohol Expectancies	Perceived Alcohol-Related Social Norms	Knowledge of Drug and Alcohol Policy	Physical Health	Healthy Diet
PHYSICAL HEALTH													
Point-of-Decision Prompts	78											★	
NoonTime Walkers	79		★			★						★	
5 A Day	81												★
Community Gardens	83					★							★
PERSONAL FINANCES													
EDSA Group® Workshops (Youth)	86				★								
EDSA Group® Workshops	88				★								
Self-Control Training	90				★								
NEFE High School Financial Planning Program	92				★								
PERSONAL COPING													
Stress and the Healthy Mind	96	★	★	★		★	★						
Unstress	98		★			★							
NoonTime Walkers	100		★			★						★	
Triple P	100		★	★		★							
Couples Coping Enhancement Training	100					★							
Community Gardens	101					★							★
Cognitive Relaxation Coping Skills (CRCS)	101		★			★							
Coping with Work and Family Stress™	101		★	★					★				
ANGER													
Cognitive Relaxation Coping Skills (CRCS)	104	★											
Changing the Sexual Aggression-Supportive Attitudes of Men	105							★					
Stress and the Healthy Mind	107	★	★	★		★	★						
RETHINK	107	★											
DEPRESSIVE SYMPTOMS													
Feeling Good	110			★									
MoodGYM	112		★	★									
BluePages	114			★									
FeelBetter	116			★									
Family Thriving Program	118					★							
Triple P	118		★	★		★							
Stress and the Healthy Mind	119	★	★	★		★	★						
Coping with Work and Family Stress™	119												
THOUGHTS AND BELIEFS ABOUT ALCOHOL AND DRUGS													
Alcohol Expectancy Challenge	124								★				
Team Awareness	125										★		
Coping with Work and Family Stress™	125												

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